Consume Happy: The relationship with food for fat women with a history of early psychological adversity

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In loving memory of

Jack Swannell

1. Abstract

Obesity is recognised as a worldwide epidemic; however, little is known about the psychological influences on the development and maintenance of obesity. There is increasing evidence that early adverse experience impact adult health, but very little empirical data, beyond naming emotional regulation as a mediating factor has been produced. This research project tried to fill this gap in relation to obesity. In the context of this study, the relationships with food, its origins, development and meanings were central rather than a focus on weight and the body.

Seven semi-structured interviews of women who were obese and had reflected on the impact of their childhood experiences on their weight, were conducted to collect the data and constructionist grounded theory methodology was applied to analyse the results of this study. As a result of data analysis six major categories were developed; abuse, neglect, loss, emotionally unavailable caregiver, adaptive emotional regulation strategies and food.

The analysis of the data revealed multiple adversities in the context of early interpersonal relationships which were marked by inadequate nurturing and emotional scarcity or deprivation along with a complex and multi-layered relationship to food and eating. Food offered relational intimacy, securing feelings of safety, love and connection in challenging early environments. Consequently, eating developed as a very effective emotional regulation strategy. In this context, I propose the idea of 'consuming happy' as an important and distinct process specific to this population that has its roots in the early trauma and attachment difficulties.

This research proposes that the cumulative effect of the multiple ongoing traumas and challenges of an emotionally disadvantaged early caregiving system, laid the foundation for a complex relationship with food in adulthood. In this perspective the body is not the problem; instead the body offers an insight into developmental trauma which is reflected through eating behaviours.

The implications of this study are discussed in terms of their applicability and contribution to clinical practice, service provision and in relation to the wider context of the understanding and treatment of obesity. This research is a call to recognise the interface between eating, attachment and trauma in order to offer compassionate and informed healthcare and to dismantle the prejudices held against fat individuals. Whilst this study highlighted a value of a developmentally informed, trauma-sensitive perspective to obesity, limitations of this research project are discussed and further research ideas put forward.

2. Introduction

2.1 The problem

Obesity is described as a modern epidemic. The World Health Organisation (WHO, 2018) estimated that worldwide obesity has tripled since 1975, equating to 13% of the world's population. Overweight and obesity are major risk factors for several chronic diseases and consistently associated with diminished health related quality of life (Friedman, 2000; Zeller & Modi, 2006). Once considered a problem in high income countries only, obesity is now dramatically on the rise in low and middle-income countries, particularly in urban settings.

Adult obesity levels in England increased by 18% from 2005 to 2017 (Baker, 2019), 28.7% of adults are thought to be obese and a further 35.6% overweight, making a total of 64.3% (NHS Digital , 2019). The UK governments commissioned report on obesity predicts an obesity rate of 60% in men and 50% in women by 2050 if current rates are sustained (Foresight Future Identities, 2013). The economic strain of treating obesity related illness with the associated costs of lost productivity, unemployment and absenteeism are vast and strain on the NHS is estimated to hit £9.7bn by 2050 should the current rates be maintained (Baker, 2019). The Royal College of Physicians in their introduction to Action on Obesity (2013) state

"Obesity has increased so rapidly and is now so prevalent in the UK that it is often described as an 'epidemic'. The UK is not alone with this problem but has one of the highest incidences of severe obesity in the world. Obesity has continued to occur more frequently, more severely and at younger ages than was ever imagined possible when the Royal College of Physicians (RCP) last addressed the issue in 2007. No country on the planet has successfully tackled this problem, which results in major adverse consequences for health, wellbeing, work output and life expectation" (2013, p. x).

Obesity has increased at an alarming rate and is now considered to be a worldwide public health issue due to its association with a significant increase in morbidity and mortality.

2.2 Definition of obesity

The WHO defines obesity as abnormal or excessive fat accumulation that may impair health (WHO, 2018). Obesity is measured by body mass index (BMI), a simple weight-for-height index. It is defined as a person's weight in kilograms divided by the square of their height in meters (kg/m^2). The WHO definition is:

- a BMI greater than or equal to 25 is overweight
- a BMI greater than or equal to 30 is obese
- if your BMI is over 40 is morbidly obese

The NHS states the term obese describes a person who's very overweight, with a lot of body fat (NHS.uk, 2019). The most widely used measurement method is that of BMI and waist measurements; patients with very large waists (94cm or more in men and 80cm or more in women) are more likely to develop obesity-related health problems.

2.3 The trouble with diets

The WHO claims the fundamental cause of obesity and overweight is an energy imbalance between calories consumed and calories expended (2018) and the recommendation to decrease body weight is usually through diet and exercise. Successful weight loss is a decrease of 10% of body weight which is maintained for at least 1 year (Wing & Phelan, 2005). Although a 10% weight loss may not bring a fat person into the normal weight range on the BMI scale, it is well documented to lower the risk of high blood pressure, diabetes etc. (Foster et al., 2003). It is a commonly held belief that diets are very difficult and generally don't work. The research seems to be consistent with this belief. Behavioural approaches to weight loss have been used by the NHS and commercial weight loss programmes for decades. Although dieters often achieve substantial weight loss while actively dieting, most regain the lost weight in the years to follow (Cooper et al., 2001; Wing & Phelan, 2005; Curioni & Lourenço, 2005; Powell et al., 2007). Reviews of the research into weight loss consistently shows that only 20% of overweight people succeed in maintaining a weight loss of 10% or more of the baseline weight for one year in behavioural and dietary interventions (Garner & Wooley, 1991; Teixeira et al., 2005) and over half returning to the pre-diet weight (Curioni & Lourenço, 2005). Dieting may even result in weight gain with some research showing that involvement in a formal weight-loss programme is a predictor of weight gain in the following years (French et al., 1994), which may contribute to the cycle of yo-yo dieting that is familiar to many dieters. Furthermore, research suggests that short term highly restrictive diets may be psychologically and physically harmful (Burmeister et al., 2017).

Diets don't work for the clear majority of individuals and many sources (Bruch, 1957; Goodspeed Grant & Boersma, 2005; Buckroyd & Rother, 2008; Waumsley, 2011; Foresight Future Identities, 2013; British Psychological Society, 2019) argue that the reasons behind weight gain are more complex than willpower, calorie counting and exercise. Instead they have to do with "neglect, lack of trust, lack of love, sexual abuse, physical abuse, unexpressed rage, grief, being the object of discrimination, protection from getting hurt again" (Roth, 1992, p. 4).

2.4 NHS weight management services

There are four tiers of weight management services in the NHS. While definitions vary locally usually tier 1 covers universal services (such as health promotion or primary care); tier 2

covers lifestyle interventions; tier 3 covers specialist weight management services; and tier 4 covers bariatric surgery. Lifestyle interventions recommended for sustainable weight loss include dietary change and encouragement to increase physical activity, in combination with expert support and intensive follow-up. If this conventional treatment is unsuccessful then a referral to tier 3 services is recommended. This includes options such as specialist low calorie diets, drug treatment for those with a very high BMI and referral to tier 4 surgical interventions (NICE Pathways, 2019). However, it is recognised that treatment pathways and options vary locally.

Nice Guidelines (National Institute for Health and Clinical Excellence, 2014) also reference behavioural interventions with the support of an appropriately trained professional. This is based on CBT principles including self-monitoring of behaviour and progress, goal setting, problem solving, cognitive restructuring, reinforcement of changes, relapse prevention and strategies for dealing with weight regain.

From reviewing NHS treatment pathways, it appears that psychological based treatment (behavioural change) is an optional add-on to what is considered a biological problem. In 2011 the British Psychological Society (BPS) report on obesity stated that "psychological issues are generally not receiving as much attention as sociological and diet issues as ways of tackling the growing obesity epidemic" (Waumsley, 2011, p. 3). While the BPS advocate for an understanding of the interplay of biological, psychological and social factors, their primary recommendations for psychological input in the prevention, management and treatment of obesity is based on behavioural sciences (2019). Additionally, they recommend that interventions should be tailored to individual's specific needs, with increasingly comprehensive and intensive programmes for those with complex and enduring obesity. For this group a psychological formulation of the individual's obesity related precipitating and perpetuating concerns should be available and treatment delivered by a psychologist with experience of working with trauma at all levels (BPS, 2018; 2019). The NHS England's 'Five Year Forward View' (2014) recommended more psychological input and integration in obesity services. However, the BPS (2019) argue that in practice, provision of holistic specialist obesity services across the UK varies greatly with significant gaps, adding the challenge is to ensure that these guidelines are followed.

2.5 Discrimination and bias

From research and professional experience in the field we know that obesity is not a 'choice' or simply down to a lack of willpower. People become overweight or obese as a result of a complex combination of biological and psychological factors combined with environmental and social influences. Despite this, there is a general held belief that obesity is due to poor self-

discipline and is therefore a personal characteristic with equally negative stereotypes. These negative stereotypes drive both weight bias and discrimination and allow it to go unchallenged. Weight bias permeates into every area of society, including education (Chalker & O'Dea, 2009), employment (Rudolph et al., 2009) and healthcare. Foster et al (2003) in a US study found that doctors view obesity as largely a behavioural problem and 50% of physicians viewed obese patients as awkward, unattractive, ugly and noncompliant. Similarly, a French study reported doctor's negative views, holding stereotypes of obese patients as lazy, lacking in self-control, unintelligent, weak-willed, non-compliant, sloppy and dishonest (Bocquier et al., 2005). These studies confirm the suspicions that a large proportion of doctors share the broader societal negative stereotypes about the personal attributes of fat people. On an individual level, the medical consequences of obesity bias have been widely publicised in research (Huizinga et al., 2009), policy (Friedman & Puhl, 2012) and personal accounts such as yourfatfriend (Anonymous, 2019).

Despite growing recognition that obesity is a complex issue rather than a personal failure and the mounting evidence of consequences of fat bias, examples of the discrimination (Friedman & Puhl, 2012) and vile content (Coren, 2017) aimed towards fat people is ubiquitous.

2.6 Tackling the problem

The current trends and associated costs of obesity have not gone unnoticed with both the health risks and wider consequences of obesity widely publicised. There is a great deal being done by Government, local bodies and the NHS to try and stem the rise in obesity levels. Nationally these bodies have backed various health promotion programmes including Change4life, One You, Everybody Active, Every Day, Eatwell Guide, NHS Diabetes Prevention Programme (NHS Digital , 2019) to name but a few, all emphasising diet, exercise and behavioural change information. Information on healthy eating and exercise has flooded all aspects of life and receives much media attention.

Despite the awareness of the 'eat less, move more message' in society in addition to Government initiatives and health warnings obesity levels continue to rise suggesting that either the Government's healthy living messages are failing to get through or the wrong message is being advocated. The general approach seems to focus on obesity as a self-contained problem, attempting to address the physical symptoms without reference to broader psychological or sociological contexts. Thompson and Thomas (2000) studied the views of obese adults enrolled in weight loss treatments and found that 56% of patients agreed with the statement "nobody looks into why I am overweight they just put me on diets". Such sentiments may reflect the consequences of the eat less, move more message and suggest that many fat individuals feel there is more to their weight than simple over-eating. Although a

topic high on the political agenda, the lack of progress to stem the rising tide of an 'obesity epidemic' may be due to this sole focus on simple weight loss, with little understanding of the development of obesity.

2.7 What is missing?

As it stands, on a global scale, no country has stemmed the rising tide of obesity. The Foresight report on obesity concluded that it was simplistic to say that obesity is caused by energy imbalance. A range of complex factors were identified as contributing to obesity including; biology, metabolic and genetic factors, impact of early life and growth patterns, food intake and activity patterns, opportunities for physical activity, habits, beliefs, morals, technology, living environment, food and drink access and availability, the price of food and drink, food marketing, purchasing capacity and impact on eating patterns and the impact of working practices (Foresight Future Identities, 2013).

Psychology takes a holistic approach, considering obesity within a contextual frame; biological and psychological factors combined with environmental and social influences inform the 'biopsychosocial model' (Ashmore et al., 2008). This approach recognises that individuals and environments both have an important role to play in the development of obesity and influence each other. Attention is focused on the determinants of behaviour, rather than behaviours themselves, to understand and integrate the many complex influences on obesity within a single framework (BPS, 2019). From this perspective psychological practitioners and researchers have been advocating for a broader understanding of obesity to include psychological determinants. There is a growing view that obesity and overeating are often symptoms of a much more pervasive problem and that many of the efforts to solve and remove 'the problem' are therefore misguided.

In my practise as an Integrative Psychotherapist and Counselling Psychologist clients often present with various adapted and often unhelpful ways of coping that have become problems in and of themselves. Concerns around food use and weight are common presenting problems. These concerns, in my experience, are unlikely to be a distinct problem isolated from other issues. For many clients their issues around weight, whether they be overweight, underweight, struggling with diets or bingeing, were inseparably tangled with other aspects of their development and life experience. The relationship with food is usually an indicator or a symptom of larger issues. In that sense one person's struggle with weight, in my clinical practise, has never been the same as another's.

As a counselling psychologist viewing obesity as a self-contained issue, which can be addressed without reference to broader psychological or sociological contexts, is dissatisfying. Equally, the societal presentation of fat people as part of the same whole, who could all be

understood in the same way, is also frustrating. My clinical experience led me to question whether there is more complexity and meaning to struggles with excess weight and obesity than the common explanation of energy imbalance, which is often framed as personality or moral failings.

Given the scope and the failure to address the 'obesity epidemic' there is a call for more research into the potential of psychological approaches in the treatment of obesity (Meekums, 2005; Waumsley, 2011; BPS, 2019). Like other population groups most fat people can be expected to have some insight into their eating behaviour and what contributed to their problems, so exploring their understanding and experience seems appropriate. Sarlio-Lahteenkorva argues that this "insider perspective approach has largely been neglected in obesity research" (1998, p. 203). The research which has focused on asking fat individuals about their experience identified the missing component in weight loss attempts as the failure to address underlying psychological factors (Goodspeed Grant, 2008).

2.8 Aims of the study

The aim of this research is to explore childhood experiences of women who are currently classified as obese and discover what their subjective experience can tell us about the underlying process that may be at work.

- What childhood experiences do women identify as important in their life histories?
- Is there commonality in the subjective experiences identified?
- What does this tell us about the underlying process?

3. Literature Review

3.1 Introduction

Consistent with my philosophical beliefs and choice of constructionist grounded theory engaging with the literature review has been a non-linear process. In the early stages of the research process I conducted a thorough review of existing multi-disciplinary research and theory on the development of obesity in order to contextualise the field of study. This culminated in the research question and the justification for the study, in addition to enabling me to identify an area of focus which had previously been overlooked in the psychological literature. Throughout the research process I engaged with extant literature in order to progress the study and this was done in the context of reflexivity. This process is reflected in the structure of the thesis where literature is presented throughout the body of the study.

Substantial literature across several disciplines has developed to attempt to explain and treat obesity. Although this research is specifically orientated towards understanding the possible influences of childhood experience on adult obesity, in order to fully appreciate the complex influences involved in obesity, an understanding of this multidisciplinary approach is warranted. Obesity ultimately develops from an energy imbalance, regularly eating too many calories or living a sedentary lifestyle. However, many complex factors influence these behaviours which are embedded in the environment or outside of the person's control. This research sits within the wider biopsychosocial model where psychology plays a critical role together with environmental, biological and sociological influences.

3.2 Environment

At the beginning of the 20th century the leading causes of death throughout the world were infectious disease, in part related to deficiencies in the intake of energy and essential nutrients (Nestle, 2000). Now at the beginning of the 21st century chronic disease such as coronary heart disease, cancers, diabetes and stroke are prevalent in industrialised countries and developing countries (Popkin, 1998). The harmful effects of weight on chronic disease risk, morbidity and mortality are well established (Allison et al., 1999; Must et al., 1999; Friedman, 2000; Wadden et al., 2002).

How can we explain this dramatic change? Food production, distribution and processing have moved from low scale, locally grown, season dependent production to worldwide production of packaged and processed food. This has resulted in a food system that offers people enormous variety of fresh and processed foods throughout all seasons of the year at a relatively low cost, thereby promoting overconsumption (Nestle, 2000). Daily energy expenditure has declined with each major shift in the national economy; from agriculture to manufacturing to service industry to the current information economy. At the same time

changes to the physical environments at home, occupational, leisure spaces and transportation promotes decreased activity levels (Swift et al., 2013). Schwartz and Brownell (2007) have argued that our modern lifestyle has created a 'toxic environment' in which obesity is a predictable consequence. The term "obesogenic environment" is also used and refers specifically to "an environment that promotes gaining weight and one that is not conducive to weight loss" within the home or workplace (Swinburn et al., 1999). However, despite this obesogenic environment not everyone is obese. Biological research attempts to explain the individual differences and genetic predisposition to weight gain.

3.3 Biology

Obesity is usually understood as an energy balance regulation dysfunction (Richard & Boisvert, 2006) resulting in excess fat storage. While obesity is the consequence of an imbalance between energy intake and energy expenditure over time, understanding this energy balance alone does not address the reasons for that imbalance. Many biological factors influence that imbalance, including genetics and stress.

3.3.1 Genetics

Collectively genetic research suggests that appetite regulation, individual interest in food, satiety signals and emotional eating all have some genetic basis (Lauzon-Guillain et al., 2017). While the role of genetic factors in obesity is not yet clear, the Human Obesity Gene Map (Rankinen et al., 2005) revealed 127 genes are currently implicated in obesity. Again, although surrounded with considerable debate, the heritability of body mass index has been suggested to be 50-90% (Elks et al., 2012). Research suggests that genes prime some individuals to want to overeat in response to certain environmental triggers. Within our changing environment, the opportunity to eat more has increased and those with a strong genetic risk have become more susceptible to excess energy intake than ever before.

However, although the evidence seems clear that there are combinations of genes that predispose humans to weight gain, this does not solely explain the rapid explosion in obesity. While it is useful to have knowledge of possible predispositions to weight gain, it is not possible to know that exact impact on an individual level. This serves as a reminder of the importance of understanding individual experience rather than a focus on reducing the individual to their underlying genetics.

3.3.2 Stress

Psychosocial stress has been established as a risk factor for weight gain, albeit to a small effect (Wardle et al., 2011). The impact of exposure to chronic stress is well documented, resulting in the person's stress response system being constantly activated. This is particularly harmful for children who grow up in toxic stressful environments as their brain develops and

function in survival mode, which among other effects, alters the prefrontal cortex development responsible for attention, executive function and self-regulation (Cozolino, 2006). Within the current obesogenic environment where food is plentiful, palatable and easily accessible, the chronically activated stress system influences various biological systems that promote weight and body fat mass including the metabolic (Camacho & Ruppel, 2017), neuroendocrine (Björntorp, 2001) and neuronal pathways (Wu et al., 2016). Weight-related adaptions of these systems can together influence eating patterns, reward sensitivity, food preference, craving for hyper-palatable foods and intake under conditions of stress (Yau & Potenza, 2013).

However, even with an increase in research and knowledge of the biological underpinnings of obesity, there has not yet been a corresponding increase in success in dealing with the problem.

3.4 Sociological

Individual behaviour does not occur within a vacuum, there are various social and environmental mechanisms that shape people's behaviour. The WHO (2018) propose the driving force behind the rise in global weight is societal changes. Certain features of society itself predispose certain individuals to obesity, such as environmental influences that promote a sedentary lifestyle. In addition, an aggressive food advertising industry influences food preferences and choice, promoting overeating especially in children (Boyland & Tatlow-Golden, 2017). These influences are vital to a broader and more sophisticated understanding of obesity.

Feminist perspectives argue that rising obesity rates are a consequence of social expectations of the increasingly slim standard of bodily attractiveness for women (Silverstein et al., 1986; Orbach, 2006) that encourages disordered eating (Keel & Heatherton, 2010). Examining women's relationship with beauty from a feminist sociological perspective, Gimlin (2002) challenges the powerlessness of modern women to the onslaught of body size, arguing instead that weight is a form of personal liberation from the thin ideal of beauty. Whatever the process, sociological influences are enacted through the psychological pressures of beauty ideals.

Research consistently reveals socioeconomic inequalities in obesity. Swinburn et al. (2004) propose that obesity rates move through populations in a reasonably consistent pattern over time and this is reflected in the different patterns of obesity within socioeconomic status in low and high-income countries. In the former, prevalence is greater with high socioeconomic groups. In contrast in high-income countries, such as the UK, the burden of obesity disproportionally falls on lower socioeconomic groups (Wadden et al., 2002; WHO, 2018), challenging the easy characterisation of obesity as a disease of abundance.

While there is some variance at a macroeconomic level, the socioeconomic inequalities in obesity in the UK are unambiguously evident in children, with twice the number of children in the poorest 10 per cent of the population classed as obese compared to the richest 10 per cent (NHS Digital, 2019). The disproportionate problem of obesity is widely believed to reflect greater obesogenic environmental pressures among lower socioeconomic groups. There are more fast food outlets, selling cheaper energy-dense foods, in deprived areas (Cummins et al., 2005) and this is reflected in greater consumption (Macdonald et al., 2007). In addition, environmental challenges such as lack of parks, green space and safe play spaces encourage sedentary behaviours. These socioeconomic challenges shape individual's food and physical activity choices.

However, the burden of obesity in lower socioeconomic groups is not completely unchallenged. Bucking the trend, a Dutch study that investigated socio-demographic factors over a 6-year period did not find a causal relationship between socioeconomic status and BMI (van Lenthe et al., 2000). Whether this finding can be taken as a challenge to the status quo of economic influences on obesity or a culturally specific finding in a country marked by relatively low financial inequality is not clear. Nevertheless, what is indicated in most of the research is that obesity rates are greater in higher income countries among lower socioeconomic groups. Children born in the poorest families are more likely to experience disadvantages in their environment and early life nutrition (Demment, 2013; Caldwell & Sayer, 2019) and are more likely to experience early adversity (Wilkinson & Pickett, 2010). Consequently, they are more likely to be exposed to environments that influence their biology in ways that predispose them to excess weight gain (BPS, 2019).

3.5 Psychological

While it is difficult to separate psychological factors from biological, social and environmental influences, there are several psychological influences on eating behaviour that are associated with the development of obesity including, emotional coping skills, beliefs, mental health problems and the impact of early psychological adversity. Psychological theories aim to help understand and explain why and how people's experiences can lead them to become obese and why their best intentions to lose weight can often be overwhelmed. Understanding obesity in this way demonstrates clearly that obesity is not simply a 'choice' or that it reflects a lack of self-control.

There are several strains of psychological research that have a direct bearing on my research question and findings, which form pieces of the puzzle in psychological thinking. To begin with, my findings revealed universal eating behaviours to regulate emotions. Thus, it was important to review the literature on emotional eating and binge eating. Considering the aims of this

study, I will present some of the literature pertaining to the links between childhood experiences on adult obesity, which drive the compelling argument for research into the nature of these links. In addition, I will present the promising theory of eating behaviours linked to social and emotional experiences/memories from childhood.

3.6 Emotional eating

Emotional eating is defined as eating in response to emotional rather than physiological needs (Arnow et al., 1995) and is widely understood as a strategy for regulating negative affect (Canetti et al., 2002). Emotional eating is recognised as normal everyday behaviour in response to a wide range of affective states (Stunkard & Messick, 1985; Waller & Osman 1998; Miller, 1991; Cartwright et al., 2003; Walfish, 2004; Masheb & Grilo, 2006; Duarte & Pinto-Gouveia, 2015). The research suggests that individuals who identify as emotional eaters experience urges to eat in response to multiple negative emotions, most commonly anger, anxiety, boredom, stress and depression.

Consistently, the consumption of 'comfort food' and 'emotional eating' has been associated with improved emotional states across genders, ages and cultural backgrounds (Dubé et al., 2005). The problem being that emotionally eating usually increases consumption of food (Topham et al., 2011) and can be associated with poor health outcomes, particularly obesity (Laitinen et al., 2002).

Several theories have been put forward to explain the psychological underpinnings of emotional eating. The concept of emotional eating derived from Kaplan and Kaplan's (1957) psychosomatic theory of obesity. This theory suggests that the excessive consumption of food is a psychological defence to difficult emotional and psychological states, such as fear and anxiety (Kaplan & Kaplan, 1957). Similarly, Slochower's psychoanalytic model of obesity proposed that "overeating is used in an attempt to control an overwhelming internal anxiety state" (Slochower, 1987, p. 7). Heatherton & Baumeister (1991) also suggest psychological defence and argue that emotional eating serves to avoid negative self-awareness by shifting focus from meaningful experiences of negative internal states and cognition towards eating. The affect phobia model suggests that negative attitudes towards emotion originate from an invalidating family environment where emotion and its expression are actively discouraged or ignored. Similar to previous models, eating then becomes a defence which replaces the need to consciously experience or express emotion (Haslam et al., 2012).

Alternatively, Bruch (1961;1973) argued that emotional eating is the result of confusion between arousal state (e.g. strong emotions) and hunger which may develop from early learned behaviours. Rather than confusion, Lehman & Rodin (1989) proposed emotional eating as a psychological mechanism to increase and maintain the experience of positive

emotional states, supporting the biological reward system theories (Wu et al., 2016). Likewise, goal conflict theory proposes that rather than a response to a nutritional need, feeding and eating is associated with the expectation of pleasure outweighing the goal to restrict food (Stroebe et al., 2008).

It is important to highlight that this ever-increasing body of research and theory implies a relationship between emotional experience and food intake, thus the meanings and customs of food are important factors to consider in the development and treatment of obesity along with focus on the psychological and emotional function of food.

3.7 Affect regulation

Given the link between emotions, eating and weight gain, it has long been a priority of research to examine self-regulation skills in relation to obesity (Baumeister & Vohs, 2004). There is a strong link between emotional dysregulation and overeating in both adult and adolescent populations who binge eat (Whiteside et al., 2007) and who are obese (Ganley, 1989). Notably, measures of self-regulation outside the context of eating were found to be predictive of obesity in a population of young children suggesting that "poor emotion regulation skills may be an important risk factor in the development of obesity and not merely a consequence of it" (Graziano et al., 2010, p. 639). This research indicated that a child who fails to develop the ability to perceive and appropriately monitor emotional states may be at risk of using food in effort to regulate emotions and therefore at risk of weight gain or obesity.

Along the same lines, Tice and Bratslavsky (2000) proposed that negative mood encourages a failure to self-regulate food intake as mood regulation becomes the priority. In further exploration, they found that this occurs more often if the individual believes that eating will help improve mood, 'if you feel bad, do it' (Tice et al., 2001). Again, these findings direct attention to the role of previous experiences and personal beliefs around the power of food to regulate mood and how this developed. In my view, this not only calls for in-depth research into the individual experiences within the obese population, but also for tailored treatment that allows for exploration of the meaning and purpose of food.

Based on the body of research available, it is reasonable to conclude that emotions influence eating. Intuition indicates that the influence of emotions on eating behaviour for the obese population may be more powerful. Notably, research lends empirical support for this idea. Canetti et al. (2002) confirmed that the influence of emotions on eating is stronger and more frequent in the obese population compared to normal weight population. Epidemiological data also support the idea that higher emotional eating has been linked with higher body weight (Waller & Osman, 1998; Elfhag & Linné, 2005; Konttinen et al., 2010) and obesity (Laitinen et

al., 2002; Ricca et al., 2009). Equally, reductions in emotional eating are associated with more successful weight loss (Blair et al., 1990; Canetti et al., 2009).

3.8 Binge eating

The literature pertaining to binge eating is important for this study as research consistently shows that around half of obese individual's binge eat (Marcus & Wing, 1987; Yanovski, 2003; Yanovski, 2003a) and that it is more common in females among the obese population (Linde et al., 2004).

Evidence has steadily been accumulating connecting emotional eating, binge eating and obesity. Similar to the research around emotional eating, there has been a particular focus between binge eating and negative affect. In an influential paper, Heatherton and Baumeister (1991) proposed that binge eating serves as an avoidance strategy, specifically, avoidance of negative cognitions and their related negative emotions, a link that is well documented (Stice, 2002; Wegner et al., 2002; Hilbert & Tuschen-Caffier, 2007; Smyth et al., 2007; Stein et al., 2007; Munsch et al., 2012; Kenny et al., 2017).

Significantly, findings suggest that women with binge eating disorder have greater global negative affect than those without and negative affect increases before bingeing (Greeno et al., 2000). Experimental designs add further support to a causal link between negative affect and binge behaviours and confirm common observations about binge eating. Negative mood increases binge-eating urges (Hilbert & Tuschen-Caffier, 2007) and overall food consumption (Chua et al., 2004), as well as eating high fat foods (Goldschmidt et al., 2011), and feelings of loss of control over eating (Bodell et al., 2018).

This is a snapshot of the extensive research that supports the role of negative emotions in triggering binge eating. However, this does not address the source of the emotions or the process. Furthermore, while both emotional eating and binge eating often play a significant role in weight gain and obesity, the research focus on the emotional states that prompt these eating behaviours is not, in my eyes, the same as the psychological reason why someone turns to food. Although closely related, my interest lies in what prompted this strategy in the first place, i.e. the underlying psychological roots of obesity.

3.9 Psychological adversity

In the 1990s, a seminal US study discovered that traumatic events during childhood, termed adverse childhood experiences (ACE), are not only vastly more common than documented but are also predictive of adult health outcomes. The study found a strong correlation between ten categories of ACEs pertaining to abuse and growing up in a dysfunctional household and later adult health risk behaviours and outcomes; including depression, suicide attempts, alcoholism, drug abuse, cigarette smoking, obesity, physical inactivity, domestic violence,

sexual promiscuity and sexually transmitted diseases. In addition, with increased exposure to ACEs an individual is more likely to develop heart disease, cancer, stroke, liver diseases and diabetes (Felitti et al., 1998). ACEs, capture the cumulative effect of experiencing multiple adversities early in life (Kalmakis & Chandler, 2014) and have been suggested as a root cause of the majority of non-infectious disease (Harris, 2018). Consequently, ACEs are proposed as the leading determinant of the health and social wellbeing of a nation's population. Furthermore, from a sociological perspective, individuals who experience more social and economic deprivation also experience greater levels of psychological adversity (Wilkinson & Pickett, 2010) which places a whole section of society at a higher risk for morbidity and premature death (Bellis et al., 2015).

The original ACE study was a follow-up to the high dropout rates of successful dieters (those who lost >100 pounds) and subsequently regained the weight. When queried 'why' unexpected histories of childhood sexual abuse and noticeably dysfunctional households were remarkably common and antedated the onset of obesity (Felitti & Williams, 1998). Subsequent research controlling for other variables, found ACE exposures are predictive of adult obesity (Danese & Tan, 2014) with strong correlations between all categories of childhood maltreatment and disordered eating (Afifi et al., 2017). Longitudinal studies (Williamson et al., 2002; Greenfield & Marks, 2009), along with systematic reviews (Palmisano et al., 2018) corroborate the findings that adults reporting early abuse and adverse experiences are at greater risk of developing obesity.

Although self-reporting of childhood experiences inherently raises questions of accuracy, at the very least, reports of maltreatment are indicative of some form of seriously troubled relationship between individual and caregivers. There is significant interest and a substantial amount of literature investigating the association between adverse childhood experiences and subsequent obesity in adulthood. Collectively, these studies have consistently urged health authorities to think about health problems differently and contend that later adult health may have its footprint in childhood.

3.10 Early relationships and eating

Research is consistently demonstrating that psychological factors as well as biological, social and environmental contribute to an individual's motivation to consume food. This idea has been around for over 60 years when Bruch (1957), a leading childhood obesity researcher made the seminal plea for "a more tolerant and respectful attitude toward those who react with obesity to problems of living they cannot handle in a better way". Within psychological literature it is proposed that the pleasure gained from food can be explained by early positive interpersonal memories, in addition to nutritional or psychopharmacological properties. One

vein of psychological theory proposes that pleasurable memories and expressions of love through early socioemotional experiences influence emotional eating (Dubé et al., 2005; Goodspeed Grant, 2008). This suggests that eating in response to emotions can sometimes offer reassurance and comfort, rather than distraction or numbing. Considering the pathway between obesity and early life, Buckroyd and Rother (2008) link insecure attachment relationships with primary caregivers during childhood with obesity echoing Roth's (1992) proposed link between early life experiences and the use of food. Collectively this research and clinical experience suggests eating has strong connections with social and emotional significant memories.

In compelling research, Goodspeed Grant (2005; 2008) in accordance with Buckroyd's consistent findings, revealed emotional eaters often report difficult childhood family and social relationships, characterised by loneliness and a craving for interpersonal connection. Although sparse, this was not an exclusively unique finding. Previous qualitative research exploring overeating proposed that increase in stress during childhood may contribute to dysfunctional eating patterns (Lyons, 1998). These findings were repeated when looking at family functioning as a potential source of psychological stress. Davis *et al* (2005) found significant associations between obese women having higher anxiety levels, poorer perceptions of physical health and more psychosocial problems in the family compared with normal or overweight women. They also found that those with higher BMI ate more when they were depressed. While not addressing experiences of early life, Popkess-Vawter et al. (1998) found an important role of relationships in overeating. 'Problematic' eaters were found to overeat while isolated (or with dependants only), but while thinking about others. Whereas 'normal' individuals overate while surrounded by visible relationships but while self-focused. Whether this is a pattern set in childhood or a representation of on-going adult relationships is not clear, however the isolation and thinking of others for the problematic eaters does speak to the loneliness and craving for connection spoken about in subsequent research. Coming from a different angle, Vila et al. (2004) found that obese children identify disturbance in their families and Trombini (2003) observe a significant prevalence of insecure attachment between obese children and their mothers.

Collectively the research which has directly questioned individuals about their own explanations for their obesity have suggested that patterns of eating and relationships with food were developed in childhood. Suggested whys and wherefores included tacit rules and family interactions at mealtimes, cycles of emotional eating to control, to numb or soothe emotional pain or as substitution for unmet social and emotional needs (Goodspeed Grant & Boersma, 2005) as well as food being associated with control cycles within the family system

(Polivy et al., 1988; Lyons, 1998). Research also suggests that eating also became a way to numb the pain associated with abuse (Goodspeed Grant & Boersma, 2005; Buckroyd, 2011).

Together with research on adverse childhood experiences, these studies propose that increase in stress and maltreatment during childhood may contribute to adaptive eating patterns that can lead to obesity. The insights emerging from qualitative research suggest there is value to considering a psychodynamic approach to understanding the underlying psychological determinants of the obesity.

As noted previously, psychology sits inside a wider biopsychosocial framework and thus no single psychological theory can universally explain the phenomenon of obesity. Like any health issue, life-experience and weight gain trajectories of individuals who are obese vary considerably and will have differing complex causes. Despite the draw to understand obesity through a simplistic framework, with a one size fits all attitude, we should endeavour to remain alert to the uniqueness of the individual and not attempt to push them into the same mould. Reflecting on my own position as a Counselling Psychologist and Psychotherapist, I am predisposed to consider early life in psychological formulation. Still, the research exploring obese individuals own views seem to align with this idea and thus it seems appropriate to me that exploring early life experience may be a compelling entrance-point into understanding the underlying issues that may be the ultimate cause of overeating behaviours in adulthood.

3.11 Conclusion

Research on obesity has mainly focused on risk factors such as societal, environmental, behavioural and genetics or on the results of weight loss programmes. It is generally agreed that obesity is a multi-faceted and complex problem that includes psychological issues. Despite this there is considerably less research that looks at the psychological aspects of obesity even though emotional and psychological factors have long been associated with obesity (Bruch, 1957; Kaplan & Kaplan, 1957; Bruch, 1961; Bruch, 1973; Slochower, 1987; Herman & Polivy, 2004).

Failing to address the emotional and psychological factors when designing interventions may go some way to explaining the failure of the current treatment options in maintaining long term weight loss. Goodspeed Grant and Boersma (2005, p. 213) argue that “while experienced therapists see the wisdom in understanding the nature of a problem before planning an intervention, recommendations for weight management do not seem to take this approach”. Similarly, Raman (2013) noted that a frequent criticism of obesity research is the lack of sound theoretical background and that current interventions for obesity have largely relied on anecdotal clinical and theoretical ideas, meaning that interventions are designed without understanding the nature of the problem. The BPS make a similar appeal for exploring the

psychological determinants that contribute to obesity to enhance understanding and in designing intervention (Waumsley, 2011; BPS, 2019). In fact, all the qualitative studies reviewed have called for a more in-depth qualitative research to build a better understanding of the psychological and emotional factors that influence eating behaviours and obesity.

Likewise, as a practising Counselling Psychologist and Psychotherapist, I hoped that this exploration of early experiences of women who are obese would yield valuable insights both for myself and for other counselling professionals, to improve our understanding and treatment of clients who are obese in a clinical setting.

3.12 Research question

What childhood experiences do women who are obese consider as important in their life experience?

4. Methodology

4.1 Philosophical stance

My underlying belief that guides my integrative framework as a Counselling Psychologist and Psychotherapist is that humans are fundamentally relational beings. This perspective, rather than individualism, informs my contextual understanding of the self, healthy development and psychopathology. My view stresses the significance of context, perspective and subjectivity. This guides my confidence in the healing power of the human relationship. I approach psychological therapy as a mutual collaborative process between two subjects where relational experience is the focal point. I place the relationship at the heart of my professional stance as a psychological therapist and researcher, as well as my personal philosophy for living.

From this viewpoint, the phenomenological existentialist stance on the co-created nature of human relationships, holds great value to me and directs my outlook and thinking on human existence. We live, from start to end, in a co-created relational world that cannot be understood outside of context, situation and time. This is my reading of Heidegger's (1978) concept of 'Dasein'; we are of the world rather than in the world. I believe we are fluid open beings constantly changing and there is no authentic fixed self to be discovered. On these lines I appreciate the philosophy of Heraclitus (1995) 'no man ever steps into the same river twice, for it is not the same river and he is not the same man'.

My understanding of the business of living is governed by these ideas; that human existence is fundamentally a social existence and that development and growth are lifelong processes. We continually learn what it is to be human through our relationships and interaction with the world. I do not believe that our minds are passive. Each person's experiences give meaning to events in view of their own biography and circumstance. Consequently, reality as we know it is constructed intersubjectively through the meanings and understandings developed socially and experientially. In this view, there are multiple representations of reality that emerge from complex social, cultural and political contexts. This assumption, that our social reality is our own representation rather than a direct reading, lies within postmodern philosophy.

4.2 Research paradigm

My philosophical stance aligns with interpretive paradigm, which is founded on the theoretical belief that reality is socially constructed and fluid (Kivunja & Bawa Kuyini, 2017). What we know is negotiated within cultures, social settings and in relationships. "The social researcher is concerned to explore and understand the social world using both the participant and researcher's understanding" (Snape & Spencer, 2003, p. 16). In this research I tasked myself

to understand a developing process, as it is interpreted by each individual participant, including myself and so is grounded in the social spaces both inhabit. Knowledge is co-constructed through this interpersonal interaction and therefore it can never be judgement or value-free.

The terms social constructivism and social constructionism tend to be used interchangeably and fall under the generic term 'constructivism'. Young and Collin (2004) distinguished constructivism by its focus on how the individual mentally constructs their world of experience through cognitive processes. Constructionism, in contrast has a social rather than an individual focus and claims that knowledge and meaning are historically and culturally constructed through social processes and action (Young & Collin, 2004). Constructionists view knowledge and truth as created not discovered by the mind (Schwandt, 2003). A social constructionist position is appropriate for this research. My enquiry focuses the participant's experiences within their social world in early life. I am concerned with trying to make sense (construct an understanding) of these experiences from the perspective of those who lived it, using my knowledge and experience as a psychotherapist and counselling psychologist, as opposed to uncovering scientific knowledge or absolute truth. The social constructionist perspective proposes that knowledge sits at the intersection of the participants history, culture and society and that of the researcher (Andrews, 2012).

While I align with the idea that concepts are constructed rather than discovered, I also understand concepts as representing something real in the world; in this case the participants experience. This corresponds to the idea of subtle realism (Berger & Luckmann, 1991; Hammersley, 1992). Subtle realism proposes that while reality is socially defined, it also refers to the subjective experience of everyday life, how the world is understood, rather than to the objective reality of the natural world. This perspective, in my views aligns well to psychological research, as "most of what is known and most of the knowing that is done is concerned with trying to make sense of what it is to be human, as opposed to scientific knowledge" (Andrews, 2012, Par 6). The basis of knowledge stems from the reality around us and what we know in life is given meaning by our surrounding context (Ritchie & Lewis, 2003).

In social constructionism there is the understanding that the researcher will construct knowledge as a result of his or her personal experiences of life within the natural settings investigated (Punch, 2005). Many factors will influence how I interpret the data; including cultural, historical and life experiences, along with my educational understanding of the field and the perspective and bias that I bring to the research (Denzin, 1992).

4.3 Position as researcher

Research does not occur in a vacuum but is influenced and informed by the context in which the researcher is operating (Kenny & Fourie, 2015). In this project, it is important to

acknowledge that I, as the researcher, am an Integrative Psychotherapist and work from a relational understanding of the development of the self (Bowlby, 1969; Stern, 1985; Schore, 2012; Siegel, 2012). My view stresses the significance of developmental experience and context on the person's experience of themselves, the world and their relationship with others.

My constructionist research approach sits within the same frame of reference, expecting that the subject's (participants and researchers) past will have influence on their present-day life and experiences in the world; realties are multiple and socially constructed relative to time, place and situation. Translating this to the research process means that rather than data being self-evident to a passive value-free observer, data is co-constructed and a product of the research process. Approaching the research process as an interaction, integrates the positionality of the researcher.

This requires the researcher to take a reflexive stance and vigilance towards their interpretations, as well as those of the research participants, the research process and its outcome. My integrative theory and clinical experience have guided me to a research focus and interest and so the whole research process depends on my view and cannot exist outside it (Charmaz, 2008). My perspective, position and practices inevitably impact the interviews, type of data collected and interpretations of the data. To acknowledge my role in the research, I have maintained a close awareness of my assumptions, values, sampling decisions and interpretations of context that have shaped this project, captured in memos and through consultation with my supervisor and peers.

Engaging in this research, I hoped to advance the understanding of the early experiences of women who are obese and how this might impact their relationship with food, to offer a fresh perspective to the myths and stereotypes that are generally held across society that maintaining an 'ideal' weight is a simple formula. However, I do not presume that all experiences with fatness will have roots in early experiences. Nevertheless, given my outlined position, I targeted recruitment to those who had reflected on their early experiences and relationship with food and eating as I wanted to hear these women's stories and explore the complexity that psychological enquiry often illuminates.

4.4 Qualitative methodology

There are many qualitative research methodologies that address the messy and dynamic nature of inquiry in the postmodern context in which we live. This research aimed to investigate subjective experience and process which called for a "complex, detailed understanding of the issue" (Creswell, 2007, p.40). In keeping with this aim, the methodology employed needed to give space for a detailed exploration and understanding of the phenomenon described by the individuals participating in this study. Therefore, a qualitative research method was clearly the

most appropriate method to consider for this piece of research (McLeod, 2003). Unlike quantitative methodology, which is more suited to hypothesis testing, qualitative approaches enable researchers to provide answers to the descriptive type of questions within a discovery-oriented framework. The key advantage of qualitative research is that it enables a rich, deep and complex description of the phenomenon in question (Barker et al., 2002).

Drawing on my open-ended research question, i.e. 'what childhood experiences do women who are obese consider as important in their life experience?', I tasked myself with giving voice to the participant while allowing me as a researcher to investigate the possible influence of early life on obesity. My first challenge was to capture a respectful first-person account of individual experience, located within their particular social context. This was important to me given that fat individuals are often viewed through stigmatising imagery and information that rob them of their personal narrative and histories.

During the early stages of this project I considered various qualitative approaches and evaluated the suitability of narrative inquiry within my training group. I was initially drawn to understanding experience through "collaboration between researcher and participant" (Clandinin and Connelly, 2000. p.20). This approach harmonised with my view of research as a collective effort to construct understanding of a phenomenon rather than to discover truth. Additionally, narrative analysis allows for systematic study of personal experience and meaning and privileges positionality and subjectivity (Riessman, 2001). This approach would allow the power of personal stories and how they fashion personal identity to rise from behind the participant's appearance.

Riessmann (2001) also suggests that narrative research can illuminate the intersection of biography, history and society revealing a great deal about social and historical processes in addition to personal stories. This positions narrative inquiry as particularly relevant for eating disorders research as it provides powerful, personal and socio-cultural narratives about women and their bodies. Skultan's research of post-Soviet women's narrative of illness reflects this point. The analysis of women's personal narratives revealed "patients had a deeply historicised and social view of health and illness, and doctors interpreted psychological symptoms in physiological terms" (Skultans, 1999, p. 322). Principally, women's accounts of their hardship where erased in their physician's (biomedical) definitions of their problems. This strongly spoke to the rationale of my research, where the focus of understanding and treatment of obesity is on physiological terms (the body) with little credence given to psychological or social influence.

However, a quote from a seminar I attended (Susie Orbach) stuck in my mind; 'the more we can understand the pockets of what we don't, the more we can start to make change'. I

revisited my research goal, to understand more of the processes between early life experiences and the development of obesity.

Narrative analysis takes as its object of investigation the story itself (Riessman, 2001). While using this method may have allowed for systematic study of personal experience and meaning and possibly reveal social and historical processes, it would not have allowed me to explore the underlying processes of action that lay behind what is being said. While I wanted to understand and honour personal stories and meanings, I also wanted to understand more of the process of developing fatness, to generate a theory that would describe and explain the subject of study (Barker et al., 2002).

4.5 Grounded theory

I was drawn to the theory building aims of grounded theory (GT), which seemed to fit my goal of exploring personal experiences and to construct a tentative interpretation of what they divulge about the underlying process that may be at work. GT was originally developed by sociologists, Barney Glaser and Anselm Strauss as a method concerned with the generation of theory from empirical research (Glaser & Strauss, 1967). Unhappy about the overemphasis of verification of preconceived theory and hypothesis testing that dominated sociological research, they argued that a method was needed that would allow new theories to emerge; moving from data to theory rather than the application of pre-existing theory and constructs to the data. GT represented a significant departure from previous methods in social research as it championed an inductive approach to research with the goal of conceptualisation, rather than a deductive approach with the goal of verification (Glaser & Strauss, 1967). Achieving this objective of theory generation required the researcher to approach the study without theoretical assumptions and turn full attention to the field of study and the empirical data.

GT refers both to the research product and the method of producing it. The process of developing a theory involves the progressive identification and integration of categories of meaning from qualitative data through a rigorous process of coding and constant comparison. This enables the researcher to articulate how data obtained via interviews, observations, focus groups and other qualitative type of materials, can be used not just to provide descriptions of the phenomenon in question, but also to discover and ultimately conceptualise a theory that would explain the chief concern of the study (Barker et al., 2002).

To facilitate engaging in this process of identification, refinement, elaboration and integration of categories and ultimately development of a theory, Glaser and Strauss (1967) designed several distinct methodological techniques unique to GT. These included concurrent collection and analysis of data and employing several specific procedures, including constant comparative analysis, theoretical sampling, coding, saturation and memo writing. These

exacting techniques were designed to ensure that data is organised into increasingly abstract categories as it is collected, coded and compared, allowing a potential theory to 'emerge'. This potential theory is then edited and refined by incoming raw data, developing a mutual relationship between data and theory formation that ensures the increasing abstraction of concepts is unambiguously verified and grounded in the research itself (Kenny & Fourie, 2014). Glaser and Strauss argued that during this process of generating a theory, not only do the concepts and theory directly emerge from the data, but they have also been systematically refined by it (1967). The ambition of GT is defined by its exclusive endeavour to discover an underlying theory arising from empirical data rather than theory being applied to the subject that is being researched, thus opening a space for the development of new, contextualised theories (Willig, 2001). GT pioneered a systematic procedure for qualitative research (Charmaz, 2006) and is now a popular research method within the social sciences as it provides researchers with a rigorous methodology to study a broad range of human issues.

GT is particularly suited for studying social processes where there has been little previous exploration of the contextual factors that affect individual's lives. It gives us a picture of what people do, what their prime concerns are and how they deal with these concerns (Crooks, 2001). The motivation of exploring women's early life stories as a possible influence on their weight is a particularly under researched area that garners little credence both in existing research and societal understanding. Glaser contends that the purpose of GT is "to get through and beyond conjecture and preconception to exactly the underlying processes of what is going on, so that professionals can intervene with confidence to help resolve the participant's main concerns" (1998, p. 5). This supports the main goal of this research; to offer an understanding of the phenomenon in question from the perspective of the participants, a highly stigmatised and disparaged group, in order to improve clinical understanding and provision. Providing a voice for women through research holds promise in helping to understand both their perspective and history and thus open an empathetic space for their personhood rather than an assessment through the body alone.

4.6 Three grounded theory traditions

Grounded theory is a research methodology, consisting of three prevailing traditions: Classic, Straussian and Constructionist grounded theory. In early works Charmaz refers to *constructivist grounded theory* (2000; 2006) to distinguish it from objectivist iterations. She later refers to *constructionist grounded theory* (2008) but asserts the same definition and premise. For clarity I will refer to constructionist grounded theory.

The three traditions are differentiated by opposing philosophical frameworks and conflicting methodological directives, namely coding procedures and use of literature (Kenny & Fourie,

2015). Despite their significant divergence, the three distinct factions claim the same origin and continue to have points of methodological convergence. Straussian and Constructionist GT continue to embrace and endorse several of the foundational GT concepts that were featured in the original Classic GT presented in 1967.

The process of theoretical sampling is a fundamental principle across GT traditions. All advise that the research sample cannot be predetermined; instead, it must be a theoretical sample, openly and flexibly directed by the emerging theory until the point of saturation is reached. Another central concept in all three factions is that of constant comparison, a distinguishing characteristic of the methodology. Data are meticulously analysed through the constant comparison method and this enables the researcher to proficiently propose a theory that is credible, consistent and closely integrated with the data (Glaser & Strauss, 1967). In addition, the technique of memo writing is essential across all three versions, forming the core of GT. The ideas, codes and reflections captured in memos, prompt early analysis of the data and thus provide the fodder for the theorising process. There is also agreement on the context driven nature of GT where the theory developed is applicable only to the specific field of study and application to a wider field necessitates further research, marking a difference between substantive and formal theory. These essential characteristics (theoretical sampling, saturation, comparative analysis, memos and substantive versus formal theory) are deeply embedded within the three factions of GT.

Despite sharing fundamental tenets, the three versions diverge. Their differences essentially hinge on their opposing philosophical positions which are embedded within competing research paradigms. This gives rise to divergence in coding conventions and in contrasting use of literature.

Classic grounded theory

There is ambiguity surrounding the philosophical positioning of Classic GT. Glaser primarily conceived GT as a research method, separated from philosophical positioning (Kenny & Fourie, 2015). Although Glaser staunchly defends the classical version and heavily criticises subsequent versions, he refrains from outlining his philosophical underpinnings.

A major concern of classical GT is to facilitate theoretical concepts to ‘emerge’ from the data by researchers approaching the empirical field without preconceived theories or hypotheses (Kelle, 2005). Although theoretical sensitivity is proposed, Glaser condemns engaging with existing literature and advocates a suspension of any professional/personal experience, to ensure an open mind, free of undue influences. He argued that prior knowledge “violates the basic premise of GT” as it clouds the analyst’s ability to perceive a dynamic new concept and thereby “thwarting the theoretical sensitivity” (Glaser & Holton, 2004, para. 46). Glaser

stressed the aim of GT is to produce theories that are truly grounded in the data, that do not depend on external concepts brought to the data by the researcher.

The Classic GT coding procedure is underlined by the principle of the natural emergence of a theory to be discovered from the content of the data. In collaboration with Holton, Glaser (2004) explained that the researcher wrestles with the questions; what is the main concern being faced by the participants? and what accounts for the continual resolving of this concern? through the process of substantive (a. open and b. selective) and theoretical coding. Glaser insists that if the researcher carefully employed the coding directives, i.e. rigorously employ the constant comparison, abstain from literature and collect a large breadth of data from many different sources, that these procedures will correct the inevitable researcher bias and uncover the underlying "latent patterns" of the phenomena and ultimately "make the data objective" (Glaser, 2002, para. 24). Classic GTs pursuit of objectivity and the assertions of the researcher's unobtrusive discovery of a hidden theory reveals connotations of a naïve realist ontology.

Similarly, the concept of 'emergence' also plays down the creative role of the researcher and suggests the aim is to uncover a theory that is already there. There is an implicit positivist nuance embedded within this terminology of 'discovering' a theory which emerges from 'out there'. This view of the research process suggests that it is possible for a researcher to avoid imposing their own meanings onto the data and reflects the belief that phenomena create their own representations and are directly perceived by observers. In this sense, Classic GT takes a positivist approach to knowledge production and Willig (2001) outlines the argument that this view of the research process is not in line with principles of qualitative methodology as an inductive, open ended process.

Straussian grounded theory

The progression and maturation of GT saw a methodological and academic divergence between Glaser and Strauss, a division that prompted various publications across three decades. By 1990, Strauss developed an academic alliance with Juliet Corbin and together they refined the Classic version of GT which included a highly analytical and prescriptive framework for coding, designed to deduce theory from data systematically. The development and transformation of some of original tenets of GT shaped the alternative Straussian GT published in 'Basics of Qualitative Research: Grounded theory Procedures and Techniques' (1990).

Strauss and Corbin challenged Glaser's position on the use of literature encouraging appropriate use of literature at every stage of the study, marking the difference between an 'empty head' and an 'open mind' (Strauss & Corbin, 1990). While advising against an

exhaustive and comprehensive review to guard against becoming entrenched and blinded by the literature before embarking on research, they valued both the researchers experience and exposure to the subject as part of the research process citing many benefits including, the potential to reveal gaps in the academic literature and inspiring questions; as a guide to theoretical sampling and a secondary source of data, to provide an insight into existing theories and philosophical frameworks and as a source supplementary validation (Kenny & Fourie, 2015). Their encouragement in the use of literature from conception to conclusion is consistent with the post-positivist philosophy which accepts that the researcher inevitably influences the research.

Strauss and Corbin's (1990) major departure for Classic GT was in their reconfiguration of the coding procedure. Their coding framework is a very specific detailed method that consists of four coding states (open coding; axial coding; selective coding; conditional matrix) that the researcher moves back and forth between in consecutive coding sessions. This highly systematic and rigorous coding structure was designed *to create* a theory that closely corresponds to the data, by searching for patterns within than data, rather than *to discover* a theory within the data (Strauss & Corbin, 1990, 1994, 1998).

Strauss and Corbin argued that these specific coding directives were written for the purpose of enhancement and clarity by their spelling out "the procedures and techniques" in meticulous "step-by-step fashion" to support "persons who are about to embark upon their first qualitative analysis project" (1990, p. 8). This fastidious coding structure has been criticised by Charmaz which she classified as positivist, rigid, narrow and overly complicated (Charmaz, 2000). Glaser argues that the researcher is effectively "forcing" the data into "preconceived" concepts in order to coerce a theory (Glaser, 1992, p. 3) which contradicts the fundamental tenants of GT by adding what appears to be a deductive element. However, Strauss and Corbin believed the complexity reflects the nature of human life. They argued that their coding paradigm allows the researcher to build a "rich, tightly woven, explanatory theory that closely approximates the reality it represents" (Strauss & Corbin, 1990, p. 57). This assertion of the researcher's representation of reality is consistent with a post-positivist paradigm and located their methodology within the philosophy of symbolic interactionism. They argued that a "theory is not the formation of some discovered aspect of a pre-existing reality out there" but instead stressed that theories represent "interpretations made from given perspectives" and are forged within a culture and time and embedded in a specific historical context (Strauss & Corbin, 1994, p. 279).

Constructionist grounded theory

Charmaz, responding to Glaser and Strauss (1967) invitation for readers to use GT strategies flexibly, introduced a social constructionist version of GT which marked a radical departure from both Straussian and Classic GT. Taking the original tenets of GT, Charmaz translated them into contemporary research paradigms. Rather than the emergence of categories and theory from the data, Charmaz endorsed the researcher's construction of theory, which is inevitably influenced by the researcher's past and present involvement and interactions with people, perspectives and research practices. Charmaz reasons that "neither the data nor the theories are discovered" but rather "we are part of the world we study and the data we collect" (2006, p. 10).

Charmaz rejected Glaser's underlying philosophy of discovery of theory and the overly prescriptive Straussian coding structure intended to create a theory. Charmaz's GT is embedded in constructivist epistemology, emphasising the interviewer and interviewee's mutual construction and interpretation of data. Theory is constructed by the researcher through an interaction with the data, with the objective of presenting an "interpretive portrayal of the studied world, not an exact picture of it" (Charmaz, 2006, p. 10). Accordingly, the theory fashioned constitutes one reading of the reality rather than a truth that is discovered. Charmaz GT is unambiguously underlined by a postmodernist relativist ontology, which presupposes the existence of multiple social realities.

As noted, Charmaz's version uses fundamental GT techniques, including memo writing, constant comparisons, theoretical sampling and saturation. Charmaz GT is set apart by both its constructivist philosophy and its coding process which embraces the core principle of flexibility to encourage "imaginative engagement with data" (2008, p. 168). Charmaz argued that the prescriptive rules of Strauss and Corbin's highly systematic, rigorous coding procedures smothers the researcher's creativity and she challenges the researcher to remain flexible and tolerate ambiguity in order to be "receptive to creating emergent categories and strategies" (Charmaz, 2008, p. 168). Charmaz proposed a fluid framework with at least two stages to the process of coding (initial/open coding and focused coding) and while comparable with the two-tier structure of Classic GT is vastly more malleable.

Constructionist GT encapsulates a more intuitive and interpretive coding procedure, than previous versions (Kenny & Fourie, 2015) and was refashioned to construct a conceptual interpretation (rather than exact apprehension) of the phenomena (Charmaz, 2000; Charmaz, 2006; Charmaz, 2008). Glaser criticised Charmaz constructivist position claiming that the narrative approach created description rather than abstraction (Glaser, 1992). Charmaz (2006) and others (Bryant, 2002) defended the constructivist vision arguing that rather than

neglecting abstraction, the restructured constructivist GT weaves conceptualisation into description, particularly as the concluding story encompasses “categories, conditions, conceptual relationships and consequences” (Hallberg, 2006, p. 127).

Charmaz asserts that completing a thorough, sharply focused literature review strengthens the research argument, the credibility and authority of the researcher (2006). Furthermore, the literature review serves as an opportunity to justify and explain the researcher’s rationale in the following chapters of the thesis and to position the ensuing theory in relation to existing works. Charmaz suggested a balanced approach, employing literature at every point of the research to assist and enhance the process, but delaying total immersion in the literature review until the end of the study. This approach she argued, facilitates a comprehensive literature review without compromising the researcher’s openness and creativity and averts the danger of strangling the developing GT. In addition, Charmaz recommends that the fundamental constant comparative method does not end with the completion of data analysis but continues through the construction of the theoretical framework and the literature review.

Despite its roots as an alternative to hypothesis testing and focus on ‘emergence’ of new knowledge, the epistemological roots of both Classical and Straussian versions of GT have been challenged as positivist. The role of the researcher to various degrees has been minimised, with the focus of discovery of theory within the data. However, within a postmodern era, qualitative researchers acknowledge that “whatever emerges from a field through observation depends on the observer’s position within” (Willig, 2001, p. 78); the latter versions of GT overlook this influence of the researcher and thus reflexivity.

Constructionist GT addresses the issue of reflexivity by recognising that categories can never capture the essence of a concept in its entirety. The researchers yield an interpretive influence over their analysis and actively construct rather than neutrally discover concepts. To capture the constructionist element in the process of theory development Pidgeon and Henwood (1997) substitute the term theory generation for discovery.

Charmaz actively embraces a constructivist positioning; “we are not passive receptacles into which data are poured” arguing that “neither observer nor observed come to a scene untouched by the world” (Charmaz, 2006, p. 15). Each side make assumptions about the world, possess knowledge and experiences, occupy social status and pursue their own respective views and actions in the presence of the other. To credit this social constructionism position, the researcher is encouraged to engage in reflexivity throughout the research process. Keeping a research journal that carefully and comprehensively records how their own assumptions, values, sampling decisions, analytic technique, interpretations of context and so

on, have shaped the research project is recommended (Pidgeon & Henwood, 1997; Charmaz, 2006).

Charmaz refashioned the methodology of GT by reclaiming the potent tools of memo writing, constant comparisons, theoretical sampling and saturation from their positivist origins to forge a more flexible, intuitive, open-ended methodology which dovetails with a constructivist paradigm (Kenny & Fourie, 2015). This constructionist version follows GT guidelines but with twenty-first century methodological assumptions and approaches and includes reflexivity and interaction at its core.

4.7 Choosing constructionist grounded theory

As outlined earlier in this chapter, my view of the world acknowledges that there is no objective truth to be revealed and that a 'birds-eye' view of social reality does not exist. It is impossible for the researcher to forge an unobtrusive relationship with social research, we cannot claim scientific neutrality. Based on my philosophical values and beliefs I chose to use a constructionist GT method developed by Charmaz (2006) for this research project. This GT approach holds interpretation, not emergence, at its core acknowledging that the researcher's own assumptions and expectations will inevitably shape the research process. As a result, the theory produced constitutes one reading of the data rather than the only truth about the data (Willig, 2001). The theory develops from the interaction between the research process, the participants and the researcher's perspective.

The constructionist emphasis on the researcher and participant's co-construction of knowledge and mutual interpretation of meaning, permeates throughout the research process, through analysis and into the final outcomes. This corresponds well with my aim to develop a theory to explain from a psychological standpoint, the development of obesity, from participant's life history.

In addition, the interpretive and co-created nature of constructionist GT requires the researcher to take a reflexive stance towards the research process and its outcome. An open vigilance of personal perspective, thoughts and beliefs to developing theory ensures validity of the results and trustworthiness of the researcher. As outlined earlier, as a co-constructor in the research process I fundamentally influence the design, questions, participants, data collected and outcomes. Therefore, I make clear references to my sampling decisions, analytic techniques and interpretations of context as well as my assumptions and values that shaped and influenced this project.

4.8 Selecting the sample

In recruiting research participants, I was guided by the overarching aims of my project, i.e. to explore childhood experiences of women who are obese to discover what their subjective experience can tell us about the underlying process. I carefully considered the inclusion criteria for selecting my sample to ensure that the targeted population would address, in whatever way, the research questions I wished to explore.

I aimed to recruit women who were both interested in and importantly, had previously reflected on childhood experiences. I positioned this as my main recruitment criteria so that rich data relevant to the research question could be gathered and to ensure consistency.

Recruitment criterion that supported my research focus included:

- Participants had to be currently classified as obese with a BMI of 35 or above. I have personal experience of sitting between markers on BMI at different stages in my life. I recruited women on the higher end of the obese BMI scale to filter out those whose higher body weight owed to more situational factors and a less prominent aspect of their lives. I also focused on women who were still within this scale, to gain an experience near, lived narrative.
- I initially set the age of onset of obesity in early adulthood to filter out women who have common struggles with weight later in adulthood (e.g. after pregnancy, motherhood, menopause etc.). However, it became apparent after the first two interviews, that food and soon after, weight, became a prominent issue in childhood and adolescence. On reflection of the emergent processes involved with the relationship to food being connected to caregivers, I broadened this criterion to early struggles with food and weight and felt these women would better fulfil my target population. This had a powerful impact; I received more interest that subsequently produced in-depth interviews and rich data.
- Participants had no previous psychological therapy in relation to their weight issues. This condition aimed to guard against participants sharing a formulation of their weight from a psychological perspective, rather than their personal stories from which I would an attempt to construct an understanding of the development of fatness. I felt this would fulfil my aim to reflect and respect participant's subjective narrative before any psychological formulation.
- Participants were selected who had numerous previous struggles with dieting as I expected that this would encourage reflection. Firstly, I thought repeated dieting failures may trigger reflection that weight is about more than a calorie equation and in addition, the experience of losing weight, while the aim, may in fact illuminate a deeper struggle when weight loss reveals emotional pain or discomfort (Felitti & Williams, 1998).

- To focus on a psychological perspective, I excluded those who had organic medical issues that has caused their weight difficulties.

4.9 Recruitment procedure

The recruitment phase of this research unexpectedly was a long, frustrating process. The difficulties encountered involved a steep learning curve about my position as a researcher and how I impacted on the research process, showing that rather than above, below or outside, I stand within and inevitably influence all stages of the process, in line with a social constructionist perspective.

Recruitment involved developing different advert letters for different mediums, in response to the challenges I encountered. The adverts briefly introduced the research, the aims and outlined the criteria for participation.

Recruitment strategy

Initially I placed a hard copy of the advert letter (Appendix I) on the notice board of local weight loss and obesity support groups. In this approach I encountered significant barriers initially from the local leaders who all refused my request to leave information or introduce myself to the group and referred me to the organisation. At the organisational level, after considerable time and numerous conversations, it became apparent that I would not gain access to their networks. This was a long, laborious process that yielded no tangible results and prompted reconsideration of my recruitment strategy.

This came after one well known obesity support organisation advised me that ‘they don’t encourage their members to speak about their struggles and hardships’. Initially I was shocked; from my unlearned perspective a support organisation was encouraging silence, around an already shame laden issue and I was hoping to advance understanding. I had approached the research with the assumption that people in general want to speak about their experiences and had thought my target population and the organisations that support them, would be no different. This denial prompted an important piece of self-reflexivity needed for the research.

I initially approached recruitment in a hasty, insensitive manner without considering the many bias and discrimination that obese individuals face daily. This cemented my outsider position and highlighted my ignorance around the realities of living in a fat body. Throughout the research process I have learned that as researcher I stand within the process and impact every stage and my approach to recruitment needed to be more sensitive. To ally myself with my target population I took a subtler and nuanced approach. I slowly built an online professional social media profile around obesity before launching an online recruitment

campaign. I also reflected this stance through my recruitment procedure by allowing many steps to the process. Reflecting on the research process, I now understand the denial of access as a protective move against fat phobia that feeds the discrimination and vile attacks that the obese population habitually suffer and this in turn has influenced my discussion and recommendations.

My second strategy was to engage in an online recruitment campaign. I redesigned my advert and asked various peer groups for feedback. I used the recruitment platform Find Participants which allowed me to produce an advert suitable for online campaigns (Appendix II). The online recruitment drive involved two approaches. The first targeted relevant online forums e.g. BEAT and National Obesity forum which resulted in two participants.

I gained significant traction which resulted in five participants through a targeted social media campaign across Twitter and Facebook. I used specific hashtags to join up with relevant obesity campaigns on Twitter and shared my online add across my social media, where various contacts retweeted and re-shared. The study statistics on the webpage showed 1178-page hits over eight months. 21 women emailed to express interest and after further information was supplied, 12 remained interested from which 5 interviews were completed. The time between initial contact and interviewing took at least 15 days and I believe that this stepped process allowed potential candidates to make an informed decision and allowed me to approach the research from alongside rather than from the outside.

4.10 Participants demographics

All participants who took part were women were currently being obese, had repeatedly tried unsuccessfully to lose weight, had struggled with their weight either from their childhood or adolescence and who had reflected on and struggled with their relationship to food. BMI ranged from 36 to 42 and all had waist sizes above the recommended 80cm. One participant had recently lost 80lbs but stayed within the obese category and was currently struggling to maintain her weight-loss. Another participant recently had bariatric surgery and at the time of interview had lost 120lbs. While she remained in the very obese category, she was still losing weight rapidly. She remarked that with the weight loss her attention had turned to working on her relationship with food. Four participants were trying to lose weight while one was concentrating on a healthy relationship to her body.

Participant	Age range	Ethnicity	BMI group
1	50-55	Pakistani- British	35-40
2	35-40	White – Irish	40-45
3	35-40	White – American	40-45

4	35-40	Hispanic - American	35-40
5	45-50	White – Irish	35-40
6	25-30	White – British	40-45
7	30-35	White – Irish	40-45

4.11 Data collection

On receipt of an expression of interest in my study all potential participants were emailed the participant information sheet (Appendix III). This outlined further the rationale and aims of the study and what would be involved. If candidates were interested at this point, they were again invited to email or call to arrange an initial short phone call. During this call we discussed any issues relevant to the research and I answered questions or concerns and assessed suitability criteria. At this point, the potential participant was offered further time to reflect. When both parties were happy to proceed, we arranged a mutually convenient time for a one-to-one meeting or Skype call for a duration of up to 60 minutes. It was highlighted that interviews would be recorded and appropriate written consent (Appendix IV) was signed prior to the interviews. Contact details were provided for the researcher and the project supervisor.

Before starting the interviews, participants were reminded of the purpose of the interview and consent was double-checked. All participants were offered a copy of the tape and transcription and asked if they would like to read or contribute to the analysis and research process. One participant asked for a copy of the transcription and later the tape. Participants were reminded of confidentially and data protection arrangements, that they could stop the interview at any point and finally that they had the right to withdraw at any point before publication.

4.12 Interviews

Semi-structured interviews were conducted in a conversational manner using open-ended yet directed questions. Charmaz suggests that this interview technique fits a constructionist GT approach well, enabling rich data to be collected in what she termed “intense interviewing” (2006, p. 27). Open prompts were used at the beginning of the interviews to encourage a rapport and allow participants the time to think and reflect on the questions. All participants were asked to introduce themselves by giving a brief description of the context of their childhood and then to tell the story of important early experiences as they saw fit. All participants were keen to share their experiences, the majority of which were difficult and distressing. There was a pull to discussing current struggles with the body appearance and their adult perspective on this. This was acknowledged and the participant was gently encouraged to return to the story of their childhood and its relevance to their eating behaviour.

While I recognise that the body is a central aspect of obesity, it was not the focus of this research project.

After each interview I wrote memos on how I was feeling, the central themes that were mentioned and any early insights or hunches that came to mind. The next day, I listened to each interview in its entirety and repeated this process, letting the participants story sit with me for a couple of days before beginning coding, again using memos to record any reflections or insights.

Four participants were interviewed face to face. Two took place in their home and two in a private room of their local library. Three interviews were arranged to take place online, two due to distance and one due to travel disruptions. Due to connection issues two of these interviews were conducted over the phone. The interviews lasted between 57minutes and 1hour 18minutes with time to debrief afterward.

Whilst my decision to conduct interviews via Skype was an attempt to reach a wider audience, I was aware of the concerns and possible disadvantages around online interviewing. However, after discussion with my supervisor and considering my experience using Skype in my clinical practise, I decided that it outweighed any possible disadvantages and importantly would move my project along. However, as connection issues made Skype untenable, a mutual decision based on both participant's motivations to continue with the arranged interview, we changed to phone interviews. While this did incur challenges, including the absence of body language and eye contact, along with significantly more interruptions and pauses to the natural conversations, in both cases we found our flow and produced a rich interview and an acceptable sense of connection, evidenced by the feedback in the debrief period after the interviews.

4.13 Data analysis

As discussed earlier, I chose to use a constructionist GT method developed by Charmaz (2006; 2008) for this research project and followed the guidelines on data analysis. Due to the nature of my lengthy recruitment process and personal constraints, I certainly had to learn to tolerate ambiguity as Charmaz suggests. The process of organising codes, constructing categories and considering the relationships between them required flexibility and remained a prominent part of the process until the final draft of discussion was produced.

Data analysis was organised using the computer programme AtlasTi-V8, designed for the analysis of qualitative research data. Interviews were transcribed and uploaded to AtlasTi-V8 as primary documents. The programme allows for detailed coding, sorting, recording of

memos and theory building. This was particularly useful when navigating within and between interviews using the constant comparative method while keeping track of and storing work.

The process of memo writing was started early in research design and continued during the data collection process, analysis and throughout the life of the research. Memos were recorded in a research journal rather than AtlasTi-V8 as ideas and hunches would often emerge when I was away from active work on the research. Keeping memos in a research journal allowed me to quickly record any ideas or thoughts that came to mind.

According to Charmaz's GT data was analysed in stages:

Stage 1: Initial/Open coding

I used the principle of open coding to define what is happening in the data, i.e. naming segments of data with a label that "simultaneously categorised, summarised and accounted for each piece of data" (Charmaz, 2006, p.43). Using Charmaz recommendation, I coded close to the data, with words that reflect meanings and action rather than search for themes. At this stage I tried to keep the coding open and simple by employing speed and spontaneity.

In vivo codes were used where appropriate in order to stay close to the participants stories and "preserve meaning of their views and actions in the coding itself" (Charmaz, 2006, p. 55). These codes offer clues to implicit meanings and about the congruence of the researcher's interpretations, anchoring the analysis in the participant's worlds.

Codes were constantly revisited, added to, merged, split and renamed as coding continued across interviews. After all interviews had been completed 190 open code were produced.

Example of Open Coding in Appendix V.

Stage 2: Focused coding

The next stage involved identifying codes that were recurring or particularly significant which "made the most analytic sense to categorise the data incisively and completely" (Charmaz, 2006, p. 57). These codes condense the data and provide a handle on them and "carry the weight of the analysis" (Charmaz, 2008, p. 164). The codes that were considered significant were elevated to potential categories and then compared to the data in order to refine them (Appendix VI). Codes were compared with categories and categories with categories and some general themes identified.

AtlasTi-V8 was quite helpful at this stage as it has the capacity to report the groundedness of each code i.e. how many times it appears in the data. This aided the constant comparative method where codes and categories were identified easily for cross-examination within and between interviews. This also helped to focus later interviews to explore emerging categories

and themes. The networking function on AtlasTi-V8 was also used at this stage to help scrutinise the codes and categories.

Memo writing was particularly vital at this stage of analysis as it helped to highlight influential conditions, distinguish between major and minor categories and to trace progression (Charmaz, 2008). Memo writing pushed the work forward by following up and expanding on questions, insights, hunches, doubts etc. that arose during analysis.

Stage 3: Theoretical coding

Charmaz explains the final stage of theoretical coding as the process that specifies the possible relationships between categories that have developed through focused coding (Charmaz, 2006). Again, memo writing was key at this stage as the process of writing and revisiting memos helped to establish the relationships between the categories that moved the ideas to a more abstract analytic level, shaping the emergent theory. At this stage, I employed a diagramming technique in order to help me to organise the data visually (Appendix VII). This helped me to continue to evolve and refine the categories and understand how they related and fitted with each other theoretically. This creative exercise lead to identifying six themes and the diagrams were used to conceptualise the links between themes, with their categories and sub-categories.

4.14 Saturation and theoretical sampling

My initial intention was to recruit 12 participants who meet the NHS/ WHO guidelines for obesity and to continue as needed until theoretical saturation was reached. My aim was to explore the experiences of a specific group of people and so I used purposeful sampling, a technique widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources (Patton, 2015). I conducted the data analysis alongside data collection to elaborate and refine the categories that had developed following the initial analysis stage.

This produced some strong conceptual categories after early analysis. After the fifth interview I employed the theoretical sampling strategy suggested by Charmaz (2006). An initial conversation about the insights from the research elicited two more participants who were particularly interested in sharing their stories. These interviews were then coded in their entirety, line by line like the earlier interviews. Codes were compared to earlier codes and the provisional categories. Earlier codes and categories were re-interrogated using this constant comparison method until the categories and relationships between them seemed fully developed.

Following Charmaz's assessment that "categories are saturated when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of your core theoretical categories" (2006, p. 113), I made the decision after interview seven to stop interviewing as no new categories or themes emerged and I was happy the categories were sufficiently developed. My participants were highly motivated to share their experiences and insights, probably gained from years of struggling with the very public sphere of weight. Their willingness to participate certainly added to the richness of the data gathered (Bernard, 2001). Furthermore, my own experience as a psychotherapist alongside using theoretical sampling to focus the interview on issues of relevance provided rich and detailed examples of participants subjective experiences. As my intent was to describe and interpret a process rather than generalise a theory from the sample to a population, sampling was not a matter of representation, but a matter of information richness. Patton (2015) argues that a small sample size can be enough to reach saturation when astute and efficient methods of sampling are employed and the topic is obvious and clear. All participants spoke to their subjective experiences early and freely in the interviews and as interviews and data analysis progressed, participants spoke in depth about the interaction between caregiving, food and eating.

4.15 Validity and trustworthiness

Employing the constant comparison method, along with engagement in the process constitute the core method of GT. The rigour of GT is supported by the constant comparative method, which is in turn supported by theoretical sampling and the circular nature of the method (Gerrish, 2011). As noted in the data analysis, constant comparison method was used throughout the research process to establish analytic distinctions and make comparison at each level of the analytic work. This method keeps you interacting with the data and evolving ideas and I continually revisited, refined and elaborated codes and categories, within and between interviews throughout the research process, ensuring both robustness and validity of the findings.

To ensure the credibility of the coding process, a GT group, consisting of seven professionals from varying backgrounds was used to check the quality of codes early in the analysis process. The research was explained and each person was given an un-coded version of the transcripts. The results (Appendix VIII) were compared with the original coding and new ideas and differences were discussed. This led to the inclusion of new a code that lead to the subcategory 'protesting'. The other interviews were checked with this code in mind and it was found to be consistent across interviews. Additional quotations were also added to existing codes as a result of this exercise.

To ensure reliability two ongoing consultancy groups, one consisting of two training colleagues (doctoral candidates on the counselling psychology and psychotherapy) and the other consisting of two professional colleagues (teachers) along with my supervisor, were utilised throughout the research to discuss the analysis. I used these groups to repeat a similar exercise to check validity and quality of codes and categories. These groups were used to discuss ongoing progress and issues in the research process including recruitment of participants, use of skype/phone calls, defining categories and the emerging relationships, relevance to the research question and areas of importance to the discussion.

The participants were invited to contribute further by reviewing the results (Lincoln & Guba, 1985) to check my writing was representative, ensure accuracy and provide the opportunity to add or edit any information (member checking). Of the two respondents that expressed interest one did not read the results and one had no changes to make. However, both were happy to be contacted again if further clarification was needed. One participant did request a copy of the transcript and later the tape but made no changes to the original transcript.

In addition to using memos as an essential analytic tool, I also used memos as a mean of keeping a research journal. The reflexive practice of writing memos throughout the analysis helped to keep track of reactions, memories and interpretations and examine how thoughts and ideas emerged and how they related to each other. This also provided an audit trail to ensure clarity and validity of the analysis (Starks & Trinidad, 2007).

4.16 Role of researcher

Relationship to obesity

This research idea was initially sparked by my interest of how western media and advertisement industries portray obesity with the distinct flavour of shame and objectification. I watched with horror shows like ‘the biggest loser’ line up fat people and then criticise and humiliate them with little empathy. I wondered why anyone would want to put themselves through that experience and what their story might be. When developing the research idea, I wasn’t fully aware of or comfortable admitting the extent of my personal motivation to explore what was driving the behaviours that can lead to obesity. This was also a defensive tactic rooted in my fear of fatness. Throughout my life I have witnessed and participated in the shaming of fat people, both through my disgust and wonderment of ‘how anyone could let themselves get that big’ judging it to be free choice. While my weight fluctuates, I have never been obese, however my relationship to food can sometimes be difficult and I wanted to understand this process in order to protect myself against fatness and the negative judgement it invites.

The interviews

The interviews took place in different contexts. Those where the participants invited me to their homes or where I arranged a private space facilitated the interview process where a natural flow and shared curiosity emerged quickly. The context of the phone interviews, particularly the last minute change from Skype to phone, of course impacted the interview. Adapting to the constraints presented by these last minute changes was revealed in the narratives being more punctuated with pauses and changes in direction. However, these occurrences reduced as the interview proceeded and reflected the shift to my full concentration turning solely to the narrative. This was helped by using earphones and thus feeling close to the participant. My experience of this was that once I adapted to the change and relaxed into the interview, we found our flow. In the debrief session for both phone interviews, both participants also spoke about this gradual 'settling in' to the interview.

Relationship to the data

Data analysis, unsurprisingly was the biggest challenge in the research. My capacity to engage with painful stories and delve into data analysis while navigating the transition to motherhood and loss in my own life lead to an extended period of analysis and a malleable relationship to the data and the research process. At times this was positive, lively and engrossing, while other times it was flat and heavy, seeming like it was going nowhere. As is suggested in grounded theory, the iterative nature of going back and forth to the data continued until the full draft of the dissertation was reached. Across the almost three years of this project which included large periods of feeling overwhelmed, confused or unsure I undoubtedly had to rise to the challenge for the researcher to "learn to tolerate ambiguity" in the process (Charmaz 2008, p. 168). Constructionist grounded theory presented many challenges; as a psychotherapist it was unsettling to break down stories and I worried about whose voice was coming through. I struggled with this process of moving from description to conceptualisation evident in my struggle to define the categories and in the various versions of a discussion I initially produced that merely rehashed the findings. Grasping how Charmaz' (2000) concept of the researcher and participant's co-construction of knowledge related to my research allowed me to move forward in presenting an interpretive depiction of participants' experiences using my knowledge in the field psychotherapy and related fields for my discussion.

4.17 Ethical considerations

I have adhered to the Metanoia Institute, Middlesex University and British Psychological Society guidelines on ethics. The research was approved by Metanoia's Ethics Approval Board (Appendix IX). Confidentiality matters were outlined in the Research Information Sheet and Consent Form and reiterated to the participants verbally prior to the interview. Several

safeguards were taken throughout the process to ensure that the confidentiality and anonymity of the participants was protected. Informed consent was ensured by discussing involvement in the research with participants both before arranging and immediately prior to conducting interviews. A signed consent (either paper based or electronic) was obtained for all participants prior to the interviews. This was signed by both the interviewer and the participant and each kept a copy. Whilst this consent form held the name of the participant it was not linked in any manner to the interview and filed in a locked cabinet without any reference to the research. Interviews were stored in audio format on a secure password protected folder on a locked computer. A numerical code was assigned to the interviews but held no information regarding the identity of the participant. This code followed through to the transcript and was used in analysis. Care was taken when transcribing interviews not to record any personal identifying information. Any words or phrases which might identify the participant were replaced by 'xxx'

Participants were informed verbally and in writing of the aims of the interview and that their information would be treated anonymously and that they have a right to withdraw from the study at any time until publication. It was made clear to participants that they could stop the interview at any stage. One participant did ask to stop the recording during the interview (Appendix X). During the debrief we discussed confidentiality and anonymity, reviewed the tape and the point of ending and she confirmed her consent to contribute in the study. We agreed extra time before I started analysis to allow space for the participant to process her experience and ask any further questions regarding anonymity and confidentiality. She was reminded that she could withdraw at any time before publication.

Given the sensitive topics that the research proposed to study I was alerted to the challenge, as a psychotherapist carrying out qualitative research, to be mindful of the difference between a research interview and therapy (Etherington, 2004). In recognising the possible risks from being asked to recall stressful or emotive early experiences, especially when considering the research of Williamson (2002) and Felitti (1998), care was taken to allow space for the participant to reflect on involvement and to ask any further questions regarding anonymity and confidentiality between the initial phone call and the interview taking place. Before each interview I researched suitable support information for counsellors, support organisations and online support should the participant need. An open ended debrief session was included after each session and an offer of a further debrief provided. While participants did use the initial debrief to discuss insights and give feedback none of the participants required a second debrief.

Both sensitive and traumatic material did emerge in the interview process, however, rather than upsetting or re-traumatising, most participants reported to have found the interview process cathartic. Four of the participants remarked in the debrief that they were surprised that they had gained insights and made connections through their involvement in the interviewing process which started from expressing interest in the study to reflecting afterward on the study. One remarked that previous therapy had helped her reflect on her experience of sexual abuse. Another participant said being able to talk with friends and seek support after the #metoo movement had helped her work through her distress and start to understand her experience of sexual abuse prior to the interview. One expressed a 'renewed energy and bounce' at revisiting her story with fresh ears. A significant number also expressed their gratitude as they felt validated by having told their story without receiving judgement or renewed encouragement to lose weight.

5. Findings

As a result of data analysis six major categories were developed; abuse, neglect, loss, emotionally unavailable caregiver, adaptive emotional regulation strategies and food. The categories and sub-categories are listed below as a guide to the forthcoming section.

Category 1: Abuse

- Physical abuse
    - Physical assault
    - Violent and excessive punishment
- Sexual abuse
    - Defined sexual abuse
    - Undefined sexual abuse
- Emotional Abuse
    - Terrorising
    - Spurning
    - Negative attitudes
    - Ignoring the child
- Peer bullying

Category 2: Neglect

- Physical neglect
    - No appropriate supervision
    - No protection against abuse
    - Physical danger
    - Unmet basic needs
- Emotional neglect
    - Failure to recognise child's individuality
    - Developmentally inappropriate responsibilities

Category 3: Loss

- Parental bereavement
- Parental separation
- Slow distancing of parental relationship

Category 4: Emotionally unavailable caregiver

- Inaccessible caregiver
- Caregiver's mental health

- Caregiver's physical health
- Caregiver substance abuse
- Parenting style
    - Dismissive/Rejecting
    - Uninvolved
    - Authoritative
- Caregiver temperament
    - Intense reactions
    - Unaware
    - Unresponsive
- Caregiver's emotional regulation skills
    - Unable to regulate self
    - Inappropriate reaction to child
- Lack of understanding and empathy
- Cultural norms
- Family norms

Category 5: Adaptive emotional regulation strategies

- Emotional avoidance
- Relational withdrawal
- Control
- Protesting
- Internalising difficult emotions

Category 6: Food

- Managing feelings with food
    - Emotional eating
    - Change of subject to eating
    - Learned from caregiver
    - Family norm of emotional eating
    - Eating manage distress
    - Eating to forget
    - Lack of support/alternative options
    - Overeating
- Eating to feel good
    - Limited emotional expression/awareness

    - Lack of emotional language
    - Eating changes emotional state
    - Timing of strategy
    - Power of strategy
    - Child understanding
- Food and the early family environment
    - Family meals
    - Caregiving
    - Learned overeating
    - Celebration
    - Rewards
- Eating and humiliation
    - Negative comments
    - Attack on eating norms
    - Food as punishment
- Secret eating
- Adult relationship to food

5.1 Overall findings

The analysis of the data revealed multiple adversities in the context of early interpersonal relationships which were marked by inadequate nurturing and emotional scarcity or deprivation along with a complex and multi-layered relationship to food and eating.

Abuse, neglect and loss represent the early experiences identified by participants which collectively were difficult, traumatising and most often occurred within the context of the family system, which collectively have been termed early adversity. The fourth category, emotionally unavailable caregiver is a complex category representative of the emotional atmosphere that is both influenced by and influences the other five categories. It encapsulates both the relationally/emotionally impoverished context in which early traumas occurred and the prolonged attunement and nurturing disruptions that were trauma in themselves.

In addition, the emotionally unavailable caregiver category reflects the tone of early emotional experience, the consequences of which are captured in the category, adaptive emotional regulation strategies. These strategies have the common thread of avoidance and disconnection which in turn affects several aspects of development.

The food category is influenced by the other five categories and concurrently represents the participant's emotional life and their relationship to food. Unsurprisingly food was identified as

an emotional regulator, however a novel finding was the important difference between emotional eating and what I suggest as 'consuming happy'. This category also reveals strong links to the emotional nurturance of food substituting for early unmet needs in attachment relationships. The impact of these phenomenon is reflected in the lifelong struggles with food and weight.

5.2 Abuse

The first and most striking theme across interviews was one of early abuse experiences and the corresponding compromised emotional development throughout the life cycle. All participants spoke of a range of early difficulties with primary caregivers and others inside the home. Two participants reported multiple instances of sexual abuse, two repeated and severe physical abuse within the home environment and emotional abuse or neglect were ubiquitous. This supports connections in previous research between obesity and childhood abuse (Felitti & Williams, 1998; Grilo & Masheb, 2001; Felitti, 2002; Grilo et al., 2005). Alongside the abuse experiences was a sense of isolation in their distress evident in the emotional void where caregivers were unable or unwilling to provide empathy or support. The difficulties associated with the emotional environment were often referenced by all participants and confirmed both in their reports of feeling unworthy, confused, betrayed, angry and isolated and in their caution of others and relationships.

5.2.1 Physical abuse

In this research physical abuse was a prominent feature for two participants who suffered systematic physical abuse in childhood. This included excessive and violent punishment as well as consistent attacks from older siblings far beyond the micro-aggressions that may be considered normal amongst siblings. These findings add personal narratives, with in-depth descriptions and consequences, to the literature demonstrating an association of childhood physical abuse with obesity risk (Boynton-Jarrett et al., 2012).

One participant described the repeated unjustifiable beatings inflicted upon her by the wilful and cruel punishment from her stepfather, summed up in her statement:

> *5.52 Em, he, well he bullied me horrendously you know physically beat the shit out of me kicked me whipped me you name it.*

Another participant was repeatedly physically assaulted by her older brothers (who later became quasi caretakers) and took the form of hitting, pushing, kicking and choking. The intensity of these ongoing assaults required many trips to A&E.

> *2.4 Em basically violent and emotional em I had several trips as a child to [local children's hospital] to get X-rays. One time he eh pushed me against the front room*

door so hard that my head left a dent in it [said through stifled laughter] that my head broke through it so that was a trip to A&E [said through stifled laughter].

Along with numerous examples of beatings, severe, unpredictable and unexplained punishment and random day-to-day pushes, kicks and thumps, these women lived in a state of perpetual threat, undoubtedly born from their constant vigilance of where their next beating would come from.

5.59 *Were you afraid of him? Terrified of him. Terrified. Absolutely and there was no rhyme or reason to his you know (physical punishment and beatings).*

A particularly upsetting element of the abuse was that it was public and unchallenged. The above participant said of her stepdad:

5.52 everyone was scared of my Stepdad anyway; people knew he was a scary person.

5.2.2 Sexual abuse

In line with a review into the literature between childhood sexual abuse and obesity that found 'at least a modest relationship between the two' (Gustafson & Sarwer, 2004, p. 129) two participants in this study were the victim of repeated childhood sexual abuse by persons known to the them. One participant was assaulted by a neighbour, the grandfather of her close friend.

5.11 basically the grandfather locked me into the shed and the girls were the other side of the door and he abused me, molested me, em, like I never said anything to anyone cause he threatened me and he was a trusted adult as well you know?

He continually sexually assaulted the participant and later her sisters by his persistent pestering in a sexually aggressive manner throughout their childhood and teenage years.

5.20 he'd grab a boob or he'd grab your bum or just very ugh dirty old man.

The same participant goes on to describe the more confusing sexual abuse by her father. She recognises that her father being in the bathroom while she was bathing crosses the boundary of the level of privacy that would be expected for a ten-year-old girl who spent very little time with her father (once a year).

5.93 I remember him coming into the bathroom and I remember feeling so vulnerable and I remember him washing me, sponge washing me between my legs...

She clearly recognises and labels her vulnerability in this scenario. Her confusion around this experience is highlighted when she questions whether his intent was sexually motivated.

5.95 It made me feel like I was being abused you know it did give me I don't think he was mentally doing and I think I found that hard to work that out and even to say it when I've had counselling or cause I'm like, I don't think but I know it made me feel the way I felt when [referring to earlier sexual abuse]…

This confusion is echoed by another participant also spoke of her difficulty understanding and naming her experience of abuse.

7.15 my Mam's ex had a son, older than me...like 10-years, he was in our house a lot, I was alone with him and he eh… you know...ra...abused me. I didn't know at the time em… what was happening I was young you know but I knew it wasn't right…I didn't like him. Eh, mm it was only when my school friends began to talk about boys and sex and losing their virginity…em…that's when I realised I couldn't… lose it (her virginity) you know. That was hard, when that dawned on me.

These participants highlight the child's innocence and the difficulty they have in understanding the abuse experienced. Both went on to talk about the impact of the sexual abuse on their emerging identity and the relationship with their body.

5.2.3 Emotional abuse

The most common form of abuse identified was that of emotional abuse at the hands of parental figures. Emotional abuse can take various forms and be premeditated and intentional or unintentional and conditional on ongoing or specific life circumstances. In this study, I have delineated active emotional abuse as those incidents when there is an intention to hurt, degrade, scare or verbally abuse the child and include terrorising, spurning and ignoring the child, in accordance with the WHO definition.

Terrorising

This is the set of behaviours that we often think of first when we think of emotional child abuse. In this study terrorising came in the form of name calling, swearing, criticism and threats or guised as a form of punishment causing emotional harm. One participant spoke of their caretaker's inconsistency in the form of swinging from loving and available to 'hot spots' which signalled the need to avoid or manage the caretakers temper and unpredictability. The incidents described in the study form a scale dependent on the frequency and perpetrator of the abuse. For example, there were many examples of recurring verbal abuse.

1.32 My Dad em called me inside and he was swearing at me, started swearing at me, he called me a bitch in my own language, and he said, 'you're a troublemaker and you're jealous'.

Terrorising was also seen in the form of a caregiver threatening the child or their possessions with violence, threatening abandonment or unduly restricting the child's activities. One participant, who was often left in the care of her older brothers due to her parents physical and emotional absence during her childhood, described various incidents of being terrorised by her would-be caretakers without adequate protection or guidance from either parent.

> *2.70 And of course my eejit older brother threatened to bash him [her dog] oh that nearly killed me I was again I was young, em, I wasn't into double figures and eh the dogs were supposed to be downstairs in the cloakroom and eh I wanted to bring him up and I was sad about leaving him it was only for the night but I was said about leaving him and my brother basically came in and said 'get the fuck up to bed and [inaudible]' and he put his hands around his throat and grabbed him off me…and threw him into the dog bed.*

Unpredictable and unwarranted punishment also featured and numerous examples of the consistent use of threats and cruel and excessive punishment doled out under the guise of discipline were acknowledged.

> *5.59 I was washing up and there was a few dir- bits of dirt on maybe some of the cutlery… he (stepfather) came in, into the kitchen and emptied every single piece of cutlery, all the all the, everything in the kitchen basically that could be washed up I had to wash up like pots and pans all the plates cups and saucers everything in the kitchen and dry up and put away and not, not only that, that wasn't enough for him, the, my very first school disco was a week later and he said 'and you're not going to the disco' that was my punishment for not washing up properly.*

Terrorising can be understood as one-sided emotional warfare, where the perpetrator used their position of power and words to hurt, humiliate, frighten or punish the child. These incidents were not one-offs but examples of long-term behaviour towards the participant; yelling was part of a long series of yelling and the use of threats and punishment was vindictive, violent and excessive and was typical of the treatment received throughout childhood.

Spurning

Another common experience was that of concerns being dismissed or belittled and ranged from an ongoing underestimation of the impact of common childhood difficulties like peer and school difficulties to disregarding the impact of abuse or caring roles on the child.

This was seen across varied experiences, for instance a participant explained pleading with her father to return home before her mother's death and both hers and her mother's needs being dismissed.

> *2.40 (talking of her mother's illness) and then have nobody else actually acknowledging the fact that she is actually sick and of course you're fourteen so nobody listened to you [said through laughter] regardless of you're the one around her or not.*

Not being believed and cared for at such a traumatic time was experienced as rejection and in this instance had a life changing impact on the participant.

> 2.84 *The whole nobody believed me about my Mum and the manner in which she died and findings of what actually caused her death had a huge effect on me.*

Adding to her distress was that she was also subject to victim blaming, where excuses are made about intentionality rather than acknowledgement of the abuse and neglect suffered and the blame was turned onto the participant.

> *2.21 Em basically when I did eh when I was young and slightly older question why [physical abuse at the hands of older siblings] because this was ongoing em I did question it. I got told I was a spoiled little brat…*

A subtler form of rejection was evidenced by being dismissive of the child's developmental needs and perspective usually due to the caretaker's impaired or inadequate capacity to respond to the child. There were various examples of feeling belittled or the challenges faced in their lives being diminished, for example.

> *7.67 You know I did tell my Aunt one day about the bullying, it was one time my Mam was kind out of it (depressive episode) but I got the like... em... well you think you have problems eh [said through giggle] it's just a silly schoolyard disagreement… em…sticks and stones and all that. But for me like it was a big deal you know…I was miserable and then this reaction it eh just made me feel small.*

This experience of bullying being minimised was common scenario and represents a misattunement; their needs were missed.

Negative attitudes

Participants repeatedly described being the subject of negative attitudes that, over time, impacted their developing sense of identity. This was recognised in the veiled comments that were persistent and experienced as an indication of value and thus an attack to their internal sense of worth. This is clearly illustrated from one participant who talked about feeling

criticised by her stepmother's comments, not said in anger or with malice, but rather ongoing little quips that greatly impacted of sense of identity.

> *4.75 I think she would mostly make quips about me being absent minded and or me not having common sense or leaving the door open just typical kid stuff and it makes sense when I'm saying it cause my being the smart kid and the honour roll student and the, you know just being the smart one that was attacked [I see] that was very uncomfortable for me I felt like it was one of the only things I had so for her to make me feel not smart that was really really em, that had an impact.*

For one participant this manifested in the family dynamic and being ostracized with her mother as an outsider. This participant talked about consistent and very explicit messages about the mother's perceived failures in her position and her worth in the family and implicitly her position and value by association.

> 1.56 *Em it was because my Mum you know my Mum was always the outsider of the of the picture you know my Gran and my Dad were like very close eh and Mum was the outside then eh when my Stepmum turned up I was like oh I see now it's kind of shifted into them three and Mums on her own and then it you know whoever we're classified with my Mum now so its Mum an- and me em…*

Ignoring the child

A form of nonverbal behaviours that communicates a lack of interest or concern for the child is through ignoring or not paying adequate attention to the child and their needs. This can be seen in the study through a feeling of rejection vis-à-vis a lack of attention. This rejection was felt through a lack of action.

> *1.23 Dad used to sit on the sofa and my spot was next to him eh which she [step-mother] then started to take over and that was quite hard too and my Dad didn't you know didn't sort of say 'no you sit here' and you know she's a grown woman and I'm your daughter but no eh….he made it pretty pretty clear where his loyalties lied.*

Or simply of the scarcity of attention.

> *4.19 Okay I see, so you felt like your Dad didn't pay you much attention? Was that the way it was?*
>
> *Yeah, yeah I would say that, yeah absolutely.*

Or through the value placed on the interaction with the parental figure.

> 6.57 *I just can't be bothered. My birthday for example he just put a card on the porch and put £100 in [laughs]. That's it like we just don't have any emotions.*

There is a line to consider of what constitutes emotional abuse and what would be considered poor parenting. In the case of ignoring the child this may first seem not to be as severe and overt as terrorising or spurning. However, persistently ignoring also requires intent on behalf of the caregiver and leaves the child in a position of questioning their worth and sense of belonging. In this study all participants who talked about a lack of attention from significant caregivers described this as consistent and ongoing. This eventually led to a breakdown in the relationship and they all linked this to ongoing adverse effects on their self-worth or other relationships in their lives.

> *7.28 Yeah I just didn't see my Dad and I didn't know why when I was small so I just thought it was my fault you know… I wasn't good enough em or whatever and thinking about it now it probably had a lot to do with my own problems.*

5.2.4 Peer bullying

Another range of experiences that the participants talked about as a source of distress was peer bullying. This was particularly evident for one participant who spoke about the bullying she endured throughout school as the primary cause of suffering in her childhood. This started with a hurtful social rejection followed by years of unremitting teasing, or what one might call in a different context verbal abuse.

> 3.*11 I was either eleven or twelve I can't remember I had em two really good friends [emhmm] and the summer before sixth or seventh grade they wrote me a letter and sent it in the mail and it was a list of all the things they hated about me [said through laughter] and so that was very painful and I went into sixth or seventh grade I think it was sixth grade not having any friends and and em being very scared of you know who was I going to sit with at lunch and things like that.*

This highlights the fear that is generated by social rejection and she felt traumatised by the ongoing psychological torment that she was subject to *3.18 I feel like I was very traumatised by the teasing.* Although quite badly bullied for the majority of her teenage years, she later goes on to question her reactions to the bullying as overdramatic. This was a consistent phenomenon where all participants talked about some form of teasing with a sense of brushing it off as a normal part of friendships.

> *4.59 eh [yeah] terrible friends [laughs] you know just a lot of pettiness in our social circle and you know every time I hear people talking about being bullied I could say I was bullied but rarely by strangers it was mostly by people I was really close with…*

Or that others brushed it off without taking any steps to protect them.

7.21 and like teachers knew (about the bullying) but just told me to ignore it but never actually did anything to help me.

The participants who talked about bullying by peers in childhood did so with both pain and levity, a simultaneous recognition of the difficulty of the experience with an accompanying dismissal of the impact of the associated trauma due to the universally accepted normality of bullying in childhood and the assessment of this bullying as being a low-level trauma.

Unlike other forms of abuse bullying by peers is often normalised even when severe, ongoing and while in plain sight. Bullying is often written off as 'a normal part childhood' or as that old cliché as 'character-building' rather than as something that will tear you down, bit by bit. In the interviews peer bullying was minimised and the global psychological and emotional impacts unrecognised, leading to the participants to minimise the importance of their experience.

5.3 Neglect

A point to consider is the overlap between abuse and neglect. In the child maltreatment literature abuse is defined as acts of commission by intentionally inflicted behaviours that can harm a child. Neglect is defined as acts of omission including failure to provide for basic biological needs, abandonment or lack of supervision (Lutzker & Boyle, 2002). Although defined as separate entities they are often difficult to separate. For clarity, as recommended in the literature, I am presenting abuse and neglect as separate phenomena. In reality they are not independent and tend to co-occur, often overlapping making them difficult to isolate. Though this was often the case in this research, there was just reason to define separate entities in order to acknowledge and explain difference between and within stories.

This research resoundingly confirmed the findings of previous research (Lissau & Sørensen, 1994; Grilo & Masheb, 2001), with all participants reporting some form of childhood neglect. These were broadly defined into two groupings; experiences pertaining to physical neglect and those pertaining to emotional neglect.

5.3.1 Physical neglect

Physical neglect included a lack of age appropriate supervision, a lack of protection against abuse and being placed in physical danger. Failures to meet the child's basic needs for were commonplace in over half of the interviews and at the lower levels, financial strain and childcare issues were often identified.

7.43 *I was on my own after school from when I was about 7 I think, so my mum would leave out pop tarts for me when I was small, you know cause she thought it was safe for me to use the toaster and that was my dinner em but you know what else could she do, she needed to work.*

While there was an undertone of failings to provide for basic nutritional needs and suitable supervision across interviews, a lack of protection was most often referenced and was part and parcel of physical abuse. This took the form of their caregivers, namely their mothers, not acting to protect them against the violence experienced in the home. Occasionally this was put down to normal child rearing practices of the time.

> 5.74 *No and thinking about that now (physical abuse) and but then again that was the day, the way it was you know that's not me making excuses.*

However, for others, there was a clear acknowledgment of wrongdoing where both inactive and inadequate protection was afforded. One story was quite striking where the participants mother left it up to her, as a child, to recognise and intervene in the abuse rather than adequately protect her from the violence she was subject to.

> 2.9 *Em my Mum didn't know how to deal with it, my Mum put the number for ChildLine (child protection helpline in Ireland) up on the kitchen wall and said that if I ever need to ring, ring but she didn't know how to, this huge conflict between three of her kids.*

Another participant spoke about the failure of any other adult in her life to intervene in the public and long-term psychological and physical abuse that she suffered from at the hands of her stepfather.

> 5.71 *And he definitely took joy in it in front of people. And its funny cause I don't ever remember anyone saying, 'Jesus XXX that's not on' [yeah] I don't I actually don't remember anyone saying but yet when I say these things to people now like you have just said 'did no one say anything?'*

She also picks up on the lack of intervention from her mother who witnessed both the psychological and physical torment. While confused over her role she struggles with her lack of protection.

> 5.132 *Yeah and I mean I do like I have often said this in counselling, yes I do think Mum could have done more but, then I have said, but what was she doing that I didn't know she did to diffuse?*

Both these participants had a very similar process of trying to understand their mother's position to protect their close relationship. While they posed tentative questions about the lack of protection experienced, they quickly followed up with potential explanations including assigning health difficulties:

> 2.14 *The whole inability to deal with the situation (related to Fragile X) it could have been coming from her side*.

and offering context:

> 5.75 *Actually even now I would say like her mother died when she was three her father died when she was sixteen she never really as she said she didn't know what a mother was.*

Both struggled to hold the closeness they experienced with their mothers, while also acknowledging their failures to adequately protect them from ongoing and violent physical abuse.

It became clear throughout the interviews that there was a co-occurrence between abuse and neglect experiences; an observation that has repeatedly been referenced in relevant literature (Felitti, 2002; Williamson et al., 2002; Dong et al., 2003). Most obvious in this study was those who were subject to physical and sexual abuse, or those who had parents with mental health difficulties or substance abuse issues, were more likely to also suffer from physical neglect. For example, both participants who had fathers with alcoholism described various incidences of being placed in danger.

> 2.67 *he came and got me and he was as drunk as a skunk and em driving very erratically and I had to em, tell him that we needed something in the shop to get him to pull over and he went into the shop I said I'll wait here I had to take the keys and walk home.*

> 5.83 *we were driving back and this argument started between him and my Stepmum, it transpires obviously he had been drinking and he was driving us home…*

These types of experiences were described with a light and joking tone and it was clear that they were accustomed to responding to threat and cutting off from their fear response, despite their tender age.

> 2.68 *Yeah it was even then I knew it was keeping everybody safe not just me and him cause he was driving like swerving all over the road not hugely going into other lanes kind of thing but back and forth and back and forth.*

While being placed in danger in this obvious way was highlighted, the danger was also picked up on in more indirect ways in daily life. The participants talked about risk avoidance through hyper-vigilance as to their father's state and their response to either to comply or hide.

> 5.86 *I remember him coming downstairs and he had a full suit on and it was evening time like there was no reason for it and he insisted on making me scrambled eggs and they were horrible he hadn't cooked them right and I remember trying to eat them and he was real maudli- he was a real maudlin drunk em…*

The emotional toll of having an alcoholic parent was dominant, including questioning what is normal, living in fear, taking on responsibility for the parent's wellbeing, feeling at fault and avoiding social contact for fear of being shamed.

> 2.52 *ju-just the instances that th ju-just the instances that the fear not the fear the, what's the word em, the responsibility, of having an alcoholic parent…I couldn't really bring after school my I couldn't really, I didn't have many close friends anyway because I was isolating myself so much and didn't trust people in general [said through laughter] em*
>
> *You didn't trust people?*
>
> *Yeah no definitely not em, there was a couple of times I came home from school and I had brought somebody, and he was passed out in the hall em in a puddle of his own pee [soft laugh] so I didn't again [louder laugh].*

Their fathers drinking had a detrimental effect on their quality of life and learned patterns of being in relationship have continued into adulthood. Both outline their difficulty trusting in and committing to intimate relationships and described problems with interdependence, emotional attachment and fulfilment of their needs.

While knowing when a child or family needs help is a complex issue, having a caregiver with addiction problems increased the risk of physical neglect. These participants were both placed at harm in various scenarios during childhood and both recall no intervention from a caregiver or any other adult in their life. Both participants in fact recall a distinct lack of action from caregivers to intervene or protect them from further physical harm or the ongoing neglect of their basic needs.

5.3.2 Emotional neglect

Along with the neglect of basic needs for safe living conditions and protection of the physical self, there was a pattern of failure over time, on the part of a caregivers to provide for the emotional development and well-being of the child. Key experiences that seemed to have a significant and lasting impact on participants were those where age appropriate support and soothing from their caregivers was missing. Often it appeared that as children, there was an expectation that they hold an adult understanding of their caregiver's struggles, rather than their caregivers holding an adult understanding of their childhood position. This was seen in various scenarios that could be broadly categorised as failing to recognise the child's individuality and needs and assigning the child developmentally inappropriate responsibilities. The caregiver unknowingly denied the love and care needed to develop and be healthy and

secure and this in turn impaired the participant's ability to recognise and reach out for emotional nourishment and fulfilment from their parent.

Failure to recognise a child's individuality

Failure to recognise the child's needs was surpassed by various issues including cultural factors, naivety or a denial of the impact of one's actions and decisions on the child. This led to the caregiver not recognising that the child had specific needs or putting their needs first. The impact of these failures was associated with the persistency of the nature of the failings and the corresponding effect on the relationship.

One of the most painful examples of this was when one participant was asked to strip down naked and join her younger siblings at a party. The impact was clear in both her understanding of this event and in her body language where she immediately coiled up, filled with tension, lowered her head and gaze and turned away from me.

> 5.30 *I probably was about that age eight nine and I remember the kids the smaller ones were all stripped off to jump in and out of the paddle pool naked and I remember being told 'take your clothes off' and I actually that makes me feel more upset that memory than almost the molestation to be honest with you.*

This was quite a powerful example of a complete and glaring failure to recognise her individuality and to see her palpable vulnerability. While showing up in subtler instances, this failure to recognise and therefore understand and respond to the child's position was a frequently shared experience across interviews. This often was seen in the case of parental separation, where their need for emotional support and sense of security was missed. Participants spoke of an expectation they felt as children that their father's re-marriage should not impact them, their relationship with their father and their day-to-day experience.

> 1.10 *he did get married and so when he came back I just, I was gobsmacked I thought oh my god.*
>
> 4.21 *Acknowledgement of what he was doing to our family you know I needed some sort of I needed concessions is what I really needed I needed him to compensate for what he was doing and I didn't get, I didn't get any feeling of that that he was making up for the fact that he was severely impacting my life.*

Their narrative indicated that their needs were not simply denied or deemed unimportant but rather they seemed wholly invisible. They learned not to trust their father, 7.12 '*you now how can I trust him, he just never thought I would need em him'* and the continued rejection of their needs has left an unresolved rupture that had a profound impact on the quality of the relationship.

4:20 *I feel like I knew he (her father) loved me but I felt dista- I just felt distant and I certainly did not feel secure, secure enough to show him really like the type of affection that I would have wanted to show him [mm] I didn't feel comfortable doing that.*

1.37 *I mean I love him as a Dad but I don't like him at all. I don't trust him I don't like him.*

6.59 *I just felt awkward being in the same room with him (father) I just didn't know what to say to him. Like we are really different people, even as a kid like…*

The failure to recognise a child's individuality is also mediated by cultural and contextual factors. This was evident when another participant spoke about her arranged marriage. While a cultural norm and accepted by the participant, the language she used when describing her impending marriage as a teenager was strikingly ownership based i.e. *'he is mine, something for me to focus on*' and seemed to indicate a need for control that had not been afforded in her life. She spoke of the focus being on the family system and what is best for all and the corresponding price to her internal world.

1.75 Yeah yeah you know what 'don't take it to heart, it doesn't matter' (emotions) which is what my Gran would say which is good because it keeps the peace but then at what expense?

Developmentally inappropriate responsibilities

In addition to lacking the recognition and corresponding nurturing and support needed for healthy emotional development, there appeared to be an expectation that the child understands and act in ways that were beyond their years. There were many examples of participants taking on overt practical caring roles including household chores and responsibilities for younger siblings, as well as caring for a dying parent.

2.29 *From when I was about twelve she (her mother) was in and out of hospital … she ended up she couldn't get out of the bed in the end and I was having to bring bed pans to her and stuff like that to help her.*

While most caring roles were called upon at times of sickness or financial constraint, one participants identity and place in the family was based on her mothering role for her sisters. Her basic needs were supplanted by the inappropriate caring responsibilities placed on her by an uninterested father and a mother struggling to cope.

6.36 So instead of my Dad waking up when the twins cried at night, even at eight years old, I'd be propped up on my Mums bed with a baby and a bottle cause she couldn't feed them both at the same time.

There were also more covert and complicated roles of being the parents emotional support. This was highlighted by the same participant being her mother's confidante and carrying the emotional burden of adult decisions.

> *6.52 Yeah definitely like the second time they split up when I was 17 Mum came into my room before it all happened and she was like 'I need your permission to be able to split up with him because for me to split up with him you have to have the twins' And I was like, what a question, why would I ever say no just split up with my Dad obviously I had some feelings but I didn't think that was fair' I didn't think she should have come into my room and be like 'well it's up to you if I split up with your Dad.*

The realities of a parent inappropriately relying on a child for emotional support are two-fold; having developmentally inappropriate responsibilities for others whilst also missing the emotional support needed from parents.

> *7.35 sometimes I felt like I was the Mam you know cause I was doing the looking after and I was her confidante you know, sometimes she would say things to me like that she shouldn't said to me…*

When children internalise expectations to care for their parents practical and emotional needs, the relationship is reversed. This inverted child/parent relationship is understood as parentification in psychodynamic thinking, specifically in object-relations development (Winnicott, 1965) and attachment (Bowlby, 1980a). In this scenario the child learns their own needs are less important and they often become invisible. In this research, this process was evident in their hesitance to seek support from their parents.

> 6.65 *I couldn't deal with her (mother) and I didn't want her there (after her gallbladder operation). Cause I just feel awkward around her if I'm ill or I don't want her there…*

Parentified children relinquish many of the normal, appropriate activities and emotional needs of childhood, including play, socialising with peers and a focus on academic work.

> 6.41 *Oh I just wanted my Dad to step up I just wanted him to have the initiative like even growing up from like eight to 17, I kept having to tell him to do things and like instructing him how to pick up the twins and how to be a Dad [said through strained laughter] I just wanted him to do what Dads did but he never did. Or I just wanted my Mum to have time off work so I could go and do stuff I wanted to do…just normal kid stuff.*

> 2.84 *Em I changed that I suppose I lost after my Mum died the interest in school started going down drastically em… here was nobody around I was really raising myself.*

For these participants, they struggled with academic achievement and social competency throughout adolescences and into adult life. These types of deficits are common with inappropriate caring roles that involve a surrender of important developmental needs (Berman & Sperling, 1991). The suppression of practical and emotional childhood needs in service of their parents has been associated with a range of psychological difficulties including depression, shame, anxiety and social isolation (DiCaccavo, 2006). Abundantly evident in the interviews of these parentified children were struggles with anxiety disorders and maintaining relationships.

In addition, when a child is unable to provoke a caring response from the parent they become adept at anticipating the needs of others as their primary way of relating. Participants with a parentification history wore the cloak of these imbalances not only in their adult health and relationships but also in their work lives.

7.86 *I'm a carer; what else was I going to do really? It's easy for me, it's what I know.*

When the child's role is to accommodate and service the needs of parents the impact on the experience of self in relationship can be profound.

6.91 *Did you feel loved?*

No, I don't know, it's an odd word isn't it, obviously I didn't ever feel like they didn't want me, but my Mum valued the fact that I looked after the twins cause she knew she couldn't do it without me. I always get confused by that questions because I don't know how you would feel like that.

In the case of neglect, both physical and emotional, participants shared a sense of not being 'worthy' or simply not knowing what it is to be loved. This echoes Buckroyd (2011) comment that it is hard to feel lovable when your experience is of neglect.

The neglect suffered by participants was far reaching, with examples in many areas where there was a failure to provide for the safety, development and well-being of the child including health, education and emotional development. The high prevalence of neglect reported in this study was is in line with the hypothesis that neglect could be an important risk factor for the development of obesity and suggests that it should be considered within a complex framework of risk factors.

5.4 Loss

All participants spoke about the arrangement of their childhood homes and any disruptions or changes to their parental configuration through the lens of loss. Parental death has an undoubted life altering impact on children and adolescents leaving them vulnerable to several adversities, including an increased risk of obesity (Alciati et al., 2017). While parental

bereavement was a significant life event for one participant, the experience of parental loss was in the broader sense of the loss of relationship with a parental figure. There were many unique versions of this loss including those pertaining to parental separation, physical and mental health, physical distance and substance abuse issues. The commonality among these stories was rather than the challenge of the event, i.e. the separation or the parental health issues, it was the accessibility, or more accurately the emotionally inaccessibility of the parent that lead to the loss of a consistent and secure relationship. It was an emotional connection and meaningful relationship (with the felt sense of acceptance and being loved) that the participants mourned. These relationships were described through their adaptions to living with an emotionally unavailable caregiver.

5.4.1 Parental disturbance

Disruptive changes in the parental constellation were described by all participants in the study. For five participants this was the result of parental separation and had significant impact on the quality of the attachment with one or both parents. Another participant suffered the death of her mother in her early teens followed a few years later by her father. Parental disturbance was described as one of, it not the main challenge experienced in their childhood.

> *7.2 Well my parents were teenagers when they had me and I suppose their situation really had a profound impact on my whole childhood… eh from when they separated and we, me and mam like moved in with my aunty…*

Rather than the separation, it was the loss of stability not only of their living situation but of their relationships that registered as difficult.

> *4.2 Em yeah I only say my parent's divorce not necessarily in em right when it happened I was very young but eh but navigating the lifestyles for kids with split families that was always a challenge for me that was kind of in the forefront [emhmm] in terms of challenges for me as a kid I spent time between two houses, the majority of the time was with my Mom.*

The common thread running through the overarching experience of separation was the problem of maintaining a safe and secure connection with their father. For instance, one participant spoke of her feeling of being replaced by her father's new wife.

> *1.7 It was really really awful [when her father remarried] ...because em you know I was Daddy's girl I loved my Dad to bits and then it all changed.*

All these participants described various attempts to hold onto their relationship and their sense rejection from their father.

4.29 Oh yeah yeah I really did em I always grabbed onto his (fathers) interests you know in an attempt to get noticed by him and you know it worked a couple of time but it was always short lived at least from my end.

This was endorsed when she gained his attention and felt the sense of belonging that she had been aspiring toward.

4.30 What was it like for you when he did notice?

It was great it was great I felt like you know, I felt like his kid. And not just a guest in his house.

There were various attempts at forging a relationship with their father throughout participant's stories, but their shared experience was of trust being gradually eroded through a lack of recognition or repeated disappointments.

1.109 Dad used to sit on the sofa and my spot was next to him eh which she (stepmother) then started to take over and that was quite hard too and my Dad didn't you know didn't sort of say 'no you sit here' and you know she's a grown woman and I'm your daughter but no eh…

The circumstances of the separation or the physical distance, new houses, partners or siblings were commonplace and easily accepted for the most part; it was the slow loss of the paternal relationship that was talked about with both great meaning and dejection.

7.26 when my dad's wife first came on the scene I remember wanting to see him more eh I mean I did even before that... but you know he let me down a lot… that was not easy you know; it was a lot [mm]…

Unsurprisingly, the level of trust in and the value placed on the relationship was dependant on the father's role in their life and the quality of the relationship before the separation.

4.13 *Yeah I think you know my theory about that is when my by the time my Dad left my household em I really didn't get a lot of time to see him as anything but an authority figure my sister who you know five eh six years older than me she had that time to get a more well-rounded picture of him and because I didn't I think I always kept that, that image of him and he was always just really intimidating to me.*

All bar one of the participants described detached relationships with their fathers that were initially triggered by parental separation and/or physical and emotional distance. There was a shared experience of trying to maintain connection to their father and a mutual theme of disappointments and rejection. There was a sense of grief for the lost connection or the

longed-for relationship and for many was a major part of their childhood story and a significant challenge.

5.5 Emotionally unavailable caregiver

Despite multiple accounts of physical, sexual and emotional abuse, along with corresponding neglectful environments, the most salient and difficult early emotional experiences illustrated by repeated emphasis in their stories, through their vocal timbre and non-verbal ques, as well as a cognitive dissonance and questioning of the experiences, were the disappointing emotional experiences with their parents. All participants described, at the very least, times where the caregiver was inaccessible, reacting to the expression of emotion or stress inappropriately or rejecting, or alternatively, not recognising or simply not responding to the child's distress at all.

For some, their parental figure was reliably unavailable to them throughout their childhood.

> 6.37 *My Dad was just not interested he has never been interested in being a Dad, like he was there, but he was never interested.*

> 1.42 *My mum, em, my mum was there but that was it, meaning that you could see her on her wheelchair, but she didn't get over she didn't try to get involved with us…*

While for others, the blocking of emotional access to the caregiver was a recurrent reality as a result of mental health difficulties. There were many descriptions of caretaker's serious struggles with daily functioning and consequently times where they were unable to perform in their parental roles.

> 7.23 *She was depressed you know, badly, in the bed for long periods of time, so she just wasn't there to help me*.

And there were examples of being sectioned on Mental Health grounds

> 2.31 *Between my Dad and my brother em that she eh emotionally was displaying or physically she was displaying the symptoms of the emotional trauma's kind of thing. And eh they actually put her into XXX (the psychiatric hospital).*

Other issues were more specific and sporadically affected parts of functioning, for instance one participant experienced her mother as supportive and available to her, however, she struggled with functioning outside of the family home.

> *3.73 Em I don't know I mean my Mom has a lot more social anxiety em well I don't necessarily know if it's more if I just cope better with it, I mean my Mom has issues she doesn't even leave the house a lot of the time.*

For others the experience was more confusing as they struggled to make sense of the lack of connection with their caregivers. This was seen for one in the weighing up whether her father's withdrawal from the family was due to alcoholism or emotional capacity.

> 2.49 *Mm if he wasn't [drinking] he, he could be very very withdrawn like he could be…he would disappear off into the garage for hours em but I don't know if that was to go off and drink or if it was isolation, intentional kind of thing.*

Similarly, an adult perspective of the personal resource available to the caretaker at the time was used to understand their childhood experience of their caretaker's emotional absence.

> 3.75 *Yeah like I remember she wouldn't go to parent teacher conferences she wouldn't go to [yeah] school events because you know at the time I didn't know why she didn't go she just didn't go but as an adult she shared with me that 'I didn't go because I was too afraid to go'.*

Although an adult perspective is useful to help make sense of experiences the impact was apparent; a lack of understanding of their parent's disconnection and the corresponding emotional response.

> 4.38 *Hmm, [laughs] I remember and this always kind of really confused me when I was a kid I get it now that I'm a Mom was em she would always just be really put out and angry and stressed out when we would hurt ourselves so if we you know fell down skinned a knee she was just [said through laughter] she never really compassionate about it she was just like 'oh god another thing to deal with' [said through laughter]. And at the time it felt terrible at the time I was like 'what the hell'.*

Another source of difficulty was the caregiver's ability to manage their own emotions which also had a direct effect on their availability to the child. This again ranged from the caregiver having no capacity to regulate their own emotions to an inconsistency.

> *6.29 She would just cry again [laughs] and then every time she would cry as a kid I would cry. Like I don't now but for a really long time if she cried I would cry I didn't even know why…*
>
> *4.42 what does feisty mean? [Laughs] just no you know no real capacity to deal with stress yeah she would she would blow up and she you know she'd yell and she would have a look on her face and you'd know not to mess with her.*

Whether the caregivers were experienced as consistently emotionally unavailable or sporadically in their response to life events, this emotional disconnection impacts the quality of the relationship.

6.60 *No, no even, I just felt awkward being in the same room with him [her father], I just didn't know what to say to him. Like we are really different people, even as a kid like.*

7.76 yeah, y-yes my Dad I liked spending time with him but I suppose like how could I trust him like he just didn't turn up so many times and like I didn't know, like how do you say that to him? You know we didn't talk like that…

When the parental 'holding' function is impaired, the caregiver does not afford emotional access to the child and respond appropriately and promptly to affective states (Winnicott, 1965). Not only was the basic developmental need of a secure responsive caregiver not met but the freedom to express emotion was curtailed in various ways.

Often emotional expression was inhibited through a continued denial of the child's perspective and experience and thus endorsing further disconnection.

7.66 you know my Mam like never really said anything about her being sick and what it was like for me em...like all she says is I was independent and I like find it hard to be around her now...huh…at least my dad like knows he didn't try spend enough time with me.

In another realm, the interpretation of a cultural norms inhibited emotional expressivity so that the focus was on the collective to the complete exclusion of individual's emotional life.

1.80 Your you you don't count. You know you don't matter. What matters is that you get through the day and then you keep the peace it doesn't you know your feelings or whatever…

The experience within her family was simply that the concept of emotional support was not known.

1.29 *my sister dealt with it in her own way and my brother dealt with it in his own way but we could never sort of sit and talk openly about what was going on it wasn't that concept.*

Where emotional expression, connection and support was limited there were often certain states that were not available for sharing; including but not limited to sadness, anger, doubt, insecurity and rejection. An extreme example of the emotional void that participants were navigating was especially evident in one participants story. In her emotionally deprived childhood environment, she learned that difficult emotional experience could not be tolerated let alone shared and described the encouraged maladaptive strategy to avoid and isolate.

6.21 Eh as a kid, my family didn't hug, no one really if your upset you get on with it, you go into another room and you get over it you just get over it, that's how my family deals with things you get over it, if your ill you take paracetamol you get over it [laughs] it's just what they are like.

It is important to note that most participants did emphasise positive and supportive relationships most often with their mothers and offered context to their lives to explain and understand times and moments of unresponsiveness or misattunement. Parents were responding to the participants in the context of parental separation, loss, mental health difficulties, financial strain, the pressures of parenthood, social and familial issues along with their own social and emotional attachment histories. These were not efforts to minimise or excuse their own experience, but important context driving the understanding of their parent's emotional resources and mental health. Participants mostly described parents, especially their mothers, who were doing their best and their adult perspective could fully understand this position. As one participant noted she understands her reactions now as a mother herself but as a child she thought '*what the hell*'.

Despite this, participants did mainly speak about an emotional absence of main caregivers and a lack of support in relation to difficult experiences previously identified or a general lack of emotional nurturance in and of itself.

The key finding in this research was that coinciding with experiences of abuse, neglect and loss participants described emotional deprivation in their early environments and this was the primary focus of their narrative. Interviews were characterised by overtones of disregard/inattention and/or misattunement/unavailability throughout childhood from their main caregivers. In addition, various life circumstances, including separation and mental and physical illness and their corresponding stressors often hampered their caregiver's abilities to emotionally provide for their children. Between interviews, there was a scale from significant to a profound lack of emotional communication, expression and support, evidenced in their descriptions of emotionally unavailable caregivers, their isolation in distress that persists into adulthood, their attempts to gain attention from caregivers, decreased feelings of self-worth, problems with connection and belonging along with their reduced skills in emotional regulation.

5.6 Adaptive emotional regulation strategies

The shortage of containment and soothing by emotionally unavailable caregivers contributed to prolonged and unresolved negative states for participants and accordingly they employed various means to manage their experience. With a lack of other options during childhood participants learned to ignore or avoid difficult experiences and the associated feelings.

There was evidence in the narrative of various strategies such as disconnection from others, internalising difficult emotions, attempts to control their interactions with others and when in harm's way, a contained protest. All the strategies employed seemed fixed toward avoidance of the emotion itself and connection with others.

5.6.1 Emotional avoidance and relational withdrawal

A distinct lack of affect was evident in the interviews when speaking about the various traumas experienced. Participants often struggled to identify or articulate the emotional impact as exhibited in the broad portrayal of their emotional worlds, for instance *'oh it was awful, awful; it was bad'* or in the difficulty recalling or naming the emotions *'I don't, I can't remember; to be honest, I don't know how I felt, I just moved on'* and avoidance *'I kind of just avoid things I really do'*. When emotions were identified, the distinct tactic of a prompt change of subject was often employed to avoid engaging with or describing more of the affective experience.

> *6.109 So when he was next to you and you couldn't get out, what was going on for you?*
>
> *I was just panicked [laughs] really panicked. Other than that school was fine…*

The sharp change of subject was also illustrative of ongoing tension and confusion related to a subject matter that was not offered for discussion.

> 5.751 [reported conversation about her mother with her therapist] *like she even said to me 'have you ever had separation anxiety' and never ever ever and I can honestly can say that, can you see me with that [light coming through the window shining onto me] …Oh sometimes when you're sitting all you can see is a bright light. Em yeah so never but I also around the same time like thirteen-ish was when my relationship with my real father went, when I cut him off em…*

There was evidence of a dissociative process in these narratives, where the topic of the discussion was broadly not available for reflection leaving significant parts of their experiences cut off.

> *3.14 I don't remember a lot from actually reading the letter eh and I don't know whether I blocked it out because it was so painful or eh you know, really don't know [said through laughter] but I don't actually, I remember the letter but I don't remember a lot of how I felt when reading the letter.*
>
> *5.16 I don't I never remember him threatening me but I do remember him you know I don't remember obviously I've blanked a lot of it.*

The avoidance of emotions or emotional contact was often a learned behaviour within the family home, leaving no other viable alternatives.

6.30 *Yeah so she (mother) would get in her car and go out, obviously not when we were six but as we were older she would get in her car and go out and that's what I learned to do if I'm upset I will go in my car and I will drive off…*

While this may have been the standard way of relating and secured the relational norm within the family, it had the opposite effect in developing and maintaining social relationships. The pattern of minimising contact or keeping it at a safe distance inhibited the development of close supportive relationships which often became a self-fulfilling prophecy where they felt different or on the outside.

5.3 As I grew up I'm not sure I was that aware of it, but into teens then i-it really became very obvious that I wasn't like everyone else.

There was also common experience of feeling betrayed and being unable to trust in others responses or support.

2.106 Its eh eh I had no support anybody I did try to turn to but it seemed they just turn it back on me kind of thing if I did try to talk about anything they always seemed to be turned back at me so I didn't bother.

The strategy to minimise contact developed into a life strategy and all participants recognised this emotional disconnection persisted into their most significant adult relationships

4.24 sometimes it does feel like no matter how good my marriage is I have one foot out the door emotionally.

5.178 *I can never go all in (to relationships) I have to hold something back.*

Further along the scale, there was clear evidence of complete relational withdrawal which was recalled as a conscious decision to keep oneself safe from further abuse and distress. This was the result of the previous accumulation of misattunement and rejection and involved a complete physical withdrawal, i.e. cutting of contact or an emotional withdrawal, i.e. in contact but emotionally disconnected from the relationship.

1.44 Yes I shut that that relationship died back then (in response to how she managed feelings of rejection from her father).

The protective benefits of relational withdrawal were clearly explained.

2.76 Em kind of away from everything and away from anyone who could hurt me and had been hurting me. Yeah. So isolation was safety. Yeah.

5.6.3 Control

Participants talked about various efforts to control their interactions with others and the presentation of the self to others, as an effort to ignore or distract from the distress they were

experiencing. This is seen in the stories where, when asked to explore how they managed the emotional impact of their difficult experiences, the participant redirected the conversation to various scenarios where they felt more control. For instance, when asked how she managed the rejection she felt from her family, this participant immediately jumped to her marriage.

> *1.82 she said 'well how about we get your you know if we get your, get the talk going about getting engaged' and I thought 'oh okay' but then that also got me away from you know (her relationship with her father) what I can start my own life now this is my family…he was my person and I just felt I was loved and all my concentration went on him.*

There is a conscious and intentional direction of attention to an object away from a situation that was distressing, i.e. the change in dynamic and consequently her place in the hierarchy in her family system, to a scenario where she perceived herself to have a level of control. This participant highlighted something important in her use of language, repeatedly talking about her marriage as having an object that 'is mine' and signified feeling in control.

This process was echoed by various participants where their efforts to manage their emotional response were fixed around securing a sense of control. This included attempts to distract others from the source of their vulnerability e.g. complying to the image of being robust to constant peer bullying or of being very independent and thus not needing much parental support. Alternately there were attempts to satisfy others needs to distract from one's own unmet needs. This was eminently apparent for the participant who had caring responsibilities for her younger siblings. She learned to use these responsibilities to distract herself from her own vulnerabilities.

> *6.78 I'm a really controlling person but not in a horrible way [em] I just like to know when where what and I don't know.*
>
> *What do you think being in control does for you, how does it help?*
>
> *You're not vulnerable are you if you are in control. Its eh, I'm always the person who takes charge and control things. And I suppose I control my family a bit as well. I control the twins sometimes.*

5.6.4 Protest

In the context where the child had no control i.e. were subject to abuse, as well as a lack of soothing and containment from caregivers, other adaptive strategies were employed to modulate intense affect which included differing forms of protest to regulate their internal worlds. Protests were described in response to immediate physical or emotional dangers and in the context of a power dynamic, where as a child they were at the mercy of the adult or

attempting to maintain contact to the adult. To understand these reactions, they were separated into silent, passive and outward protesting.

Silent protesting involved the swallowing of vulnerability and the associated emotional states. In the face of an immediate physical or emotional danger, there is an instinctive freezing of voice, emotions or physical being. The silent protest is painfully clear in the internal scream against the fear of her father's inappropriate physical contact.

> 5.88 *Oh I remember being disgusted at him that I remember thinking he was kneeling on the floor by me he was all being really lovey and I just remember thinking 'oh my god, you know, get away from me'.*

Passive protest was seen when the swallowed vulnerabilities were redirected to a safer object. The emotional response was threatening to preserving contact with the caretaker and so was transformed. The underlying frustrations were voiced, however neither the original emotional response nor the source of the conflict were directly addressed. For example, the pain of rejection from the father was projected onto the stepmother and then advanced to the unborn sibling who provided a safer vessel to release some of the pain without threatening complete desertion from her father.

> *1.21 So where you able to talk to anybody about how you were feeling? No no way …we just hated her you know and em when she got pregnant we'd we'd call her we'd say the baby was in it 'it's coming and it's this'…*

Finally, there were examples of the expression of objections and disapprovals in opposition to something the participant was powerless to prevent. Although not addressing the offender directly, unlike a passive protest, the offender or situation was identified and the grievance was aired.

> 4.7 *I think I was often confused and angry about my Dad but it was always I would never really express that to him I was em a little afraid of him so I always vented to my older sister and to my Mom.*

The power dynamic and therefore the sense of control the participant held, seemed to mediate the response from silent to outward protest. From a completely swallowed and internal reaction to a somewhat transformed or deflected protest and is explained by the following:

> 4.47 *Yeah em yeah as a kid you know I think I would just shut down (in response to her mother's outbursts), stop what I was doing and just kind of freeze you know what else can you really do* [yeah], *I remember when I was older I would push you know I, yeah you just get that sense of rebellion like you just know even if it's your Mom you*

know they are acting insane and irrational and you just want to fight them about it and yeah I just started to do that eventually.

5.6.5 Turning in

In these threatening environments the hate, rage or pain response towards neglectful, frightening or abusive parents was shut down, swallowed or transformed in order to maintain safety and/or loving feelings thus protecting the image of the parent. The stories of abuse were recalled in a calm manner, with no sense of anger or pain but rather a confusion or distancing from the experience. The emotional distance recalling abuse experiences was acknowledged by one client.

5.13 Yeah exactly I mean as I said he was a trusted adult so and also I, and this I said, I know I sound like I am a bit cut off from it.

In contrast the self-hatred and disgust felt toward the self or the body were spoken about with vigour.

1.63 I hated myself, which I couldn't understand at sixteen you know what's going on here em but I had this loathing for myself…

5.38 I actually remember how again back to the body how shameful I- I hated my boobs I hated the pubic hair I hated my and now- obviously you know I'm thinking now where it's quite obvious the whole-body thing [mm] em yeah like I remember showering and you know cringing.

The problem faced was that expressions of anger or pain at the parental failings potentially created more danger. In addition to numbing or disconnection from their emotional reactions to the parental failures, their anger, rejection and fear were turned inward, into self-hatred and disgust of the body. In contrast one participant spoke throughout her interview with both a constant quality of anger and direct expressions of betrayal and anger towards siblings, friends and other family members. However, similarly to the other participates she did not express any anger towards her parents quite glaring neglect. She described a pattern of acting out her aggressions and power and control are strong themes in her adult relationships.

In all experiences acknowledged as important, without exception, participants internally managed, transformed, distracted or took measures to avoid potential repeat or repercussions. The all reported either a denial of or difficulties in emotional management and turning to isolating or harmful strategies. The most recognised way they managed their emotional experience was through their relationship with food.

5.7 Food

5.7.1 Managing feelings with food

In the interviews there was a range of awareness of the purpose of eating behaviour to manage feelings. This was evident from simple explicit declarations of the use food in emotional management; varying from '*I comfort ate; I ate that feeling; I ate to calm my anxiety*' to subtler assertions. These were in the form of describing distressing events or feelings followed by an unspoken understanding.

> *2.94 I don't why… I definitely secret ate. I got upset and went and cooked a dirty big fried egg sandwich.*

A common tendency was to jump to describing eating behaviour or food when discussing difficult topics in the interviews.

> *7.103 That sounds difficult (related to feeling replaced by her father).*
>
> *Yeah it was you know and around then I started to you know use my pocket money and stop at the shop on the way home from school and I knew there was no one at home and it started small, a couple of small 10p bars and I would forget about everything else and what child doesn't like chocolate right? It was my favourite part of the day when I could eat.*

All the interviewees clearly had an implied understanding of using food to manage difficult emotional experiences or explicitly reference 'eating the feeling' or 'comfort eating' as an effective way to manage their distress. For some participants they are certain that using food to manage feelings was a learned strategy from their caregivers.

> 6.*34 How did your Dad break bad news then? Yeah, he'd take us out for dinner, or take us to McDonalds or always food, always. So that's the way you learned to... Yeah so if I'd had a bad day I'd go and buy chocolate [em].*

And she goes on to identify eating as the main emotional management strategy in her family.

> *6.7 In my family, everybody is chocolate and cake mad, if you're sad or if you're celebrating or if you're bored then buy a cake [yeah] and like that's how people celebrate and do anything really in my family.*

Most participants reference 'eating the feeling' as an emotional management technique. For one participant the process to arrive at eating her feelings was different. For her the ideal of thinness was tied to the expected goal of reclaiming the relationship with her father. Her focus on food was initially through restriction, which was also an attempt at self-soothing.

1.63 I didn't know how else, and I've learned now, I didn't know how else to channel my feelings it just became like a project to put all your attentions into your food em…

She clearly identifies this process as means of managing her feelings, which later, once she decided that any meaningful relationship was over, turned to what she described as comfort eating.

Another participant again identifies comfort eating as the way she learned to deal with her distress and her narrative goes directly to describing her eating behaviour once she identifies a distressing memory or feeling. Like all participants she related to the comfort function of food and noticeable is the progression to overeating leading to what participant's in later years understood as binges.

7.5 What was that like for you? (feeling unloved because of her father's absence?) Oh, you know, terrible, awful…. em and I comfort ate, just small things at for a while…. em…but it didn't really take so long for it to escalate you know I was eating lots of rubbish, you know I would come home and eat and eat and eat. And other times, parties and things, I always asked for more cake, was constantly sneaking sweets and asking for more. I just wanted to eat…. em… and you kind of just don't recognise it as eating too much cause I just liked it you know, it felt good.

Participants did not talk about a feeling of support in understanding the emotional impact of the experiences described, instead turned to eating, which seems to intensify quickly into an uncontrolled behavioural intervention to manage distress.

3.22 So how did you learn to deal with that feeling or what did you do with those feelings? (related to peer bullying) Em [laughs] I mean looking back I think I ate that feeling em [okay] sixth grade is really when I started I would come home and I would just binge on food I would just eat and eat and eat and then eat some more.

The repetition again of the word eat and inclusion of the word binge, gives a sense of the consuming nature of a process that feels different to 'comfort eating' as it might usually be understood. There is a visual image of the amount being eaten to squash the emotion by the heavy weight of the food. It seems a very effective tool to push down and distance the distress.

4.46 How did you manage that? (related to mother/grandmother's unpredictable temper)

Yeah you know I ate [okay] I ate [laughs]. Yeah, I ate a lot and I learned that you know mostly from my Mom.

Again, there is repetition and this gives a clear picture of emotional eating escalating to overeating. The language used around the emotional aspect of their experiences is limited, more often than not feelings are not identified but rather the eating behaviours are referenced.

In one way or another they have channelled their distress into food, a strategy started in pre to early teens. There is a distressing experience identified and then the use of food to control or attempt to sooth the associated emotional response, whether that emotion is labelled or not. All participants referenced some sort of emotional eating that progressed quickly to overeating. The descriptions of 'eating and eating' give a visible sense of squashing the feeling with food and an insight into this progression of emotional eating.

The evolution in the use of food to consistently emotionally regulate was illustrated clearly when food was seen as a form of medication.

> *3.64 So I still struggle as an adult you know I put words to it, you know I have anxiety issues [okay] em and its definitely the food calms down the anxiety, I absolutely self-medicate with food.*

The phrase to self-medicate indicates the power of food to ease the distress. This highlights an important progression from comfort eating or emotional eating to using food to medicate distress, suggesting that something more powerful than comforting is at play.

5.7.2 Eating to feel good

There is evidence in the narratives that comfort eating for these participants is something more than an exercise in comforting or self-soothing, as we might usually understand the phrase. Participants often lack an emotional language around the experiences they deem important and often did not label any emotional response unless prompted to do so in the interview.

> *3.23 Em I don't I don't recall how I was feeling (when she was eating), I think I was numb [yeah] I mean I can recall how I feel when I eat now and it makes me feel better em so I imagine that's how I felt back then [yeah] but I don't really remember.*

She is numbed to her emotional experience, has limited abilities to express and manage emotions, so she eats, the result of eating is that she feels better.

> *3.26 I don't even think I had that much insight into it, it was I really like food it makes me feel good and it tastes good em I don't think I had that much insight to say I'm being teased and it makes me feel better about being teased I just remember thinking 'I just want food and it makes me feel good'.*

This goes some way to explain the process of using food to emotionally regulate and how this differs from comfort eating. There is a clear distinction from eating as helping me feel better

about my distressing experiences to, I don't know what I was feeling, I had the urge to eat because eating makes me feel good. This highlights the power of food to move into a feeling good state and may be speaking to the powerful effect that food can have on our physiology.

> *3.59 Em yeah I mean looking back on it I eh you know I just, I just remember coming home from school and being very sad going directly to snacks not even snacks massive amounts of food and feeling good while I was eating [hmm] em and that's what I remember.*

This quote crystallises this process. Here there is a recognition of the original feeling state and the immediacy and power of food to feel good. The best strategy was to move out of sadness to a feeling good rather than tolerate and self-sooth sadness. This goes beyond comfort eating as it involves overeating and moving into a different feeling state. Another participant goes on to clearly verbalise this process of eating of vast quantities of food 'to feel good'.

> *6.72 So do you think any of this impacted your relationships with food, I mean your emotions if you weren't talking about them?*
> *Just eat [em] and it generally made me feel good and it still does. And all my family do it and my sisters picked up on it. We go to the shop and buy loads of food and just eat it all.*

Eating/bingeing is usually described as enjoyable and another participant explains an important distinction between eating as a child versus an adult understanding of food and the experience of bingeing now.

> *7.98 So you know what I was thinking is that when I binge now it doesn't feel good, it makes me feel out of control cause now I know the connection to my weight and health and all that em there is all the shame and you fat greedy... all that. But when I was young, I didn't really know so back then when I was having a hard time, you know feeling crap, eating made me forget all of that, it made me feel good… em… I really just liked it, like who doesn't?*

> *3.35 when I think back on eating and food I don't think I even made the connection that if I eat I will gain weight it wasn't really until I was adult that I realised that what I put in my mouth stays in my body [laughs]. Yeah so it was more I am eating because it makes me feel good.*

These participants indicate a similar process; eating is a very effective emotional management tool, powerful enough to move from a distressed feeling state to a good feeling state quickly and also the key differentiation in understanding of eating behaviour as a child versus as an adult. This is an important distinction because:

7.121 It's hard, because that is still there em, eh... the memory that eating makes me feel good really quickly eh no matter how bad I feel… but now it just doesn't you know last so long and is more complicated. Back then it was simple.

Comfort eating and comfort food are part of everyday lingo and point towards a soothing pleasurably activity. However, there is a range of experience in what comfort eating can mean which seems dependant on experience, emotional regulatory skills, support, control, family norms and the meaning of food. The level of control overeating may be dependent on what other strategies one has to sooth distress, the level of support available and if emotional eating is used, when this was learned (i.e. before or after a connection is made between food weight and emotions). While eating for this group of participants does indeed garner pleasure, it is in a different sense. Eating involves either large amounts of food or certain types of food to quash an emotion rather than sooth it. There is a sense of an automatic push away from distress or numbness toward feeling good by eating. The motivation is not to sooth but to transform. I suggest instead of comfort eating what participants described is 'consuming happy'.

5.7.3 Early food environment

All the participants acknowledged that the beginnings of their overeating, bingeing and use of food for emotional regulation started in their early years. One possible explanation offered was the emotional environment and traditions around food were connected to family time, celebration and caregiving, garnering a sense of nurturance and belonging that eased the unmet needs for connection and belonging.

This sense of nurturance through normal family mealtime was demonstrated by a participant who suffered severe physical and emotional abuse from her stepfather in plain sight, without any intervention from her mother. Her mother was mentioned comparatively little in the interview and mainly in relation to mealtime. There is a sense of both physical and emotional nourishment from her mother through her feeding practices.

5.62 Mum fed us very well I don't mean fed us abundantly well we always had really good like vegetables and meat [yeah] and em like at one stage Mum had us all on a macrobiotic diet and you know again the hippie in her she cooked a load of lovely brown bread and all that sort of stuff…

This was echoed by another participant who referenced mealtimes and food as a time of connection with her mother, who otherwise was unavailable to her.

7.46 You know even though I didn't have the 'family' dinner was still family time…em eh…it was nice we would sit down together even if it was just me and Mam you know and it was like that was time we spent together really.

In contrast to this were families with a stark lack of boundaries around food, where rather than a coming together and nourishment, junk food had no restrictions and mealtimes abandoned and although enjoyable, was quite the opposite of sustenance.

> *6.11 My Mum was that. Not so much with food we just ate whenever (identified as junk food), we were never the kind of kids that had breakfast, lunch and dinner, we just ate even now we just eat when we are hungry.*

Overeating as a learned behaviour was another version of experiencing nurturance and connection through food and was most obvious in the cases where participants identified their mothers as obese.

> *4.47 Yeah you know I ate [okay] I ate [laughs]. Yeah, I ate a lot and I learned that you know mostly from my Mom my grandmother was more of a feeder I think she ate vicariously through us but my Mom was also doing a lot of the eating and feeding.*

Here eating and feeding is associated with both an early learned norm and of caregiving. Food and the relationship to it, has significance in the family and can be a means of feeling nurtured in an environment of emotional scarcity or inconsistency. It can also be an intergenerational learned behaviour that attaches great meaning to relationships.

Both normal to more problematic eating behaviours, when linked to nurturance and connection become very complex and problematic to step out from underneath. Food had a multi-faceted role within families and further complications arose when food was associated with celebrations, pleasant memories and contact experiences in the family. All bar one participant reference family time and celebrations being food orientated.

> *5.122 like our family would definitely be, a lot of our love is based around food funnily enough [yeah] and eating and sitting at the table and all our celebrations were food orientated.*

This association of food with positive relational experiences and bonding was further strengthened when food was used a reward system, for either basic good behaviour that adhered to the family rules or for achievement and success.

> *4.52 Emhmm okay so it (food) was a way to deal with stress?*
>
> *Yeah but it also a bonding thing too and a reward system too if you got a good grade or you know well behaved you'd go and get something.*

Food was used as reward system and a celebratory tool and in addition as an aide to connection and belonging. The instances of connection through food ranged from normal everyday occurrences, to special treats and quality time, to examples of incompetent

parenting. One participant, who described her father as neglectful, uninterested and spoke of him with resignation, gave one example of positive feelings for her father in being excited for his return home from work which brought the promise of chocolate.

> *6.9 He did nights, so he would come home about half six seven (morning) and we'd hear him come in [em] cause we were only young and he'd give us a chocolate bar [laughing] oh it's so bad but as a kid it was really exciting [em] cause your Dad was home and you had chocolate.*

Her father seemed to demonstrate his care through the positive experience of feeding his children chocolate which developed into very incompetent parenting '6.8 *he'd wake us up and we would just eat chocolate*'. This participant later discusses her health issues and how they are complicated by her very rigid and unhealthy relationship with chocolate. *6.14 Chocolate was like massive, even now like I can go days without eating actual food and just live on chocolate [em] that's all I ever want.* She seems unable to take care of her basic nutritional needs, an inability to feed herself grown from the neglect of her basic needs as a child.

The emotional atmosphere surrounding food developed through a sense of nourishment from family traditions and connection/belonging through positive relational experiences. This seems especially important in households were there was uncertainty and disrupted or insecure attachment. Food often held happy memories of nurturance and connection to caregivers, in a sometimes unresponsive, unpredictable, neglectful or abusive environment.

5.7.4 Eating and humiliation

Food provided a powerful route both into 'feeling good' and a sense of connection and nurturance to caregivers. However, for all the participant's food did not remain clear and simple. Instead it was fused with humiliation and shame becoming a double-edged sword imbued with both suffering and pleasure. Participants recalled very painful experiences of feeling humiliated by both explicit hurtful and underhand comments to do with their eating behaviour.

> *2.93 Can you remember how you felt when he said that? (called a fat blob and greedy pig)*
>
> *Hurt… [em]… And embarrassed.*

This sense of humiliation was often coupled with confusion as the negative reactions and underhand comments were made by a usual food ally, in one case her grandmother, who she had known as someone who nurtured her through food.

> *4.86 my grandmothers focus was mostly with the food but it felt like an attack on the weight as well so one of her things was to offer offer offer food and of course I would*

take I would just take anything offered to me and em and there was a time when she offered me three or four things I took them I ate them she offered me the fifth thing I said yes and she said 'you're supposed to say no thank you'.

Her use of the word attack illuminates the strength of confusion and disillusionment she felt in this experience and there is a sense of the goal posts shifting.

4.88 my grandmother would pick us up after school would offer to would offer to take us somewhere for something would consistently do that but the one time she didn't and we asked for it she kind of made a remark 'like oh its always about food with you isn't it'…and I embarrassing, I remember feeling embarrassed.

This participant had developed, with strong implicit and explicit communication around the personal and family role of food, an overall positive relationship to food as a source of pleasure and of nurturance. She also identifies the sting in the tale, where she is left feeling shame for that same encouraged and accepted stance towards food.

Similar experiences around layers of meaning were offered and again highlight the destabilising effect of the goalpost shifting. Another participant experienced connection to her grandfather and her wider family as a result, through his offering of extra dessert with a smile and wink until he made an underhand comment about her eating that filled her with deep sense of shame and left her shocked and worried about her place in the family.

7.6…and then one day it just changed with one comment (from her grandfather), 'oh (participant name) is here get yours quick or there will be none left for the rest of us' you know… and he scowled at me, no nod no special little girl and I thought shit, you know that's it he doesn't want me here anymore.

The clear paradox concerning food as a source of connection, nurturance and celebration versus food as a source of rejection and shame was repeatedly tussled with. This was not only with treats and extras, but with normal and encouraged eating behaviour.

5.63 we were one of those families you don't see it very much anymore but we'd always have the bowl of potatoes and the bowl of vegetables in the middle of the table so that would be were my Stepdad got a lot of you know a lot of bullying in that especially if there was company, so we'd finish whatever and go and say 'can I have another potato' or something and he would just start 'you greedy fat bitch' and you know 'you're fucking, you're just a fucking greedy pig' all just really nasty stuff [yeah] around eating and food…

There is a visceral sense of humiliation here and the impact of this and the other subtler forms outlined cannot be underestimated. Food changes from a source of pleasure to having a

darker side full of shame and rejection. Importantly, this is confounded by the already complex relationships with food that all the participants identify. The idea of restricting food to control weight moves from something that from the outside seems straightforward to a concept that may trigger very difficult experiences, emotions and meanings that are multifaceted, painful and protective.

5.7.5 Secret eating

One impact of the humiliation that was felt around food was that of secret eating. This was especially clear for those participants where food was a source of both love and humiliation. It seemed a self-protective measure to continue to engage in the pleasurable activity that felt nurturing without the fear of exposure.

> 4.89 *Yeah I mean I think from then I always felt scrutinised about how I ate. There times where I would subterfuge around what I ate I would try to be subtle about what I was eating and you know just to avoid any gaze around it or having to have a conversation about it having to justify what I was eating. I would you know I would always take some measures to do that.*

The message of being greedy is internalised, yet food is still needed (for physical and emotional nurturance) and eating needs to be hidden.

> *5.68 Yeah that I was greedy and I mean definitely I-I and I hear myself saying it to myself you know when I'm in a binge mode especially [mm] and I know with me and my sister definitely we both started to secret eat around that because of that [humiliation from her step-father at the dinner table].*

The above participant began to hide food and eat in secret because of the torment at the hands of her stepfather. Eating was perilous and multifaceted bringing both humiliation from her stepfather and emotional and physical nurturance from her mother, driving the sense of being loved and unlovable at the same time. It begins to become clear how complex the messages and relationships around food become.

> *7.78 it was after that I think I remember that feeling of shame and fear, but yeah after that and this was before I began to get chubby you know, before I was being called fat or any of that, but I had this sense that what I was doing was wrong you know the food I was eating. I felt like I was being looked at so I just started to eat it in private like whenever I could just normal stuff em cause I wasn't going to stop I still liked eating it still made me feel good you know*.

The sneaking and hiding of food seem to have developed not from hiding a binge that may now end in shame and disgust but from hiding normal eating behaviours like asking for seconds at dinner or healthy snacks or accepted family eating patterns.

> *5.127 we'd sneak apples you know you'd find under our beds was just apple cores*.

As a result of, or possibly in addition to, the more obvious and outward humiliation described above there was also a sense of being watched and judged for what they were eating.

> *4.18 no one had ever slapped food out of my hand I was never starved you know nothing like that but that scrutiny that we had talked about before that was always a thing and it felt like I needed to guard and be somewhat sneaky around my food.*

The humiliation, exposure and ultimately shame felt around these normal eating behaviours was associated with their relationship with food and internalised as something 'bad or wrong'. It is clear to see the how difficult it is to separate the shame from eating.

5.8 Lifelong coping

All participants spoke about their current struggles with their weight, which has been an issue for most of their adult lives. They spoke about their repeated failures with diets and frustrations of something seemingly so simple being so hard. There was a paradox in recognising the emotional meaning and use of food and an expectation to easily change the way in which food was used in order to lose weight. Or an understanding of weight at a purely physiological level despite earlier assertions of comfort eating and using food to manage emotional life.

> *2.95 Em I've like since I've finished in my eh just previous relationship with the abuse I think that in two months I've dropped down from a size 26 to a 22… without changing much …the weight is just coming off itself kind of thing…. Em I think its em a complete stress related thing. If you're eating and your body is not functioning properly to metabolise it if you get* me?

However, some were starting to appreciate their difficult relationship with food was not exclusively tied to their body.

> 3.*77 I'm a hundred and twenty pounds lighter…I'm still you know I'm only nine months out from (bariatric) surgery em and you know food is still a big struggle of mine … I definitely need to figure out the relationship I have with food and work on that.*

The difficulty of unhooking emotional life from eating was demonstrated by one participant's struggle to understand and separate the two. This participant had a good awareness of her eating behaviours being influenced by her early years. However, she had not addressed her history of relational trauma nor learned any other ways of managing her emotional world. She

was both living her life at a distance from others, not allowing herself to experience relational intimacy and had found herself constantly tripping at the last hurdle of her weight loss goals, returning to her long term and trusted eating habits. She expressed frustration at the constant battle and the feeling like she is still not quite 'getting it'.

> *5.14 where does it flip that you gain that understanding? (about the relationship between her eating, her emotions and her history) And you actually start to live? because that is where I am, the past three or four years in that and I'm so frustrated by it that I can't.*

She described two sides of herself, one of knowing and understanding her relationship with food and the other which lives the knowing and experiences her emotional world through eating.

> *5.145 When will the two of them sort of weigh you now sort of yeah balance up and just go like that [clasping hands together] and then it would be like that's it (indicating her understanding her food relationship and putting that into practice). And like I strive constantly to get those two, but they are like that the whole time [holding hands apart] like no and just when I think I do, like, even the thing about being half a pound off the first half a stone in four months, like wow, which is really shit but even that little thing I'm gone… I was so near to it and it was so doable but what did I do this week? Complete mess up… back up again.*

One participant spoke about an acceptance of her fat body. She also spoke about the journey to get there, learning to separate food and feelings and to process her emotions when she was hungry.

> *4.14 the first thing I recognised was about how I ate and how it affected my core ability to have emotions and to deal with life…*

She spoke about actively learning new ways to be and to feel and the realisation that she will continually work on her internal world.

> *4.119 Gosh em I mean if anything I have learned that I am never done with this kind of introspection I'm just never done…*

Figure 1 below, is as an illustration of the relationship between the categories presented in this section.

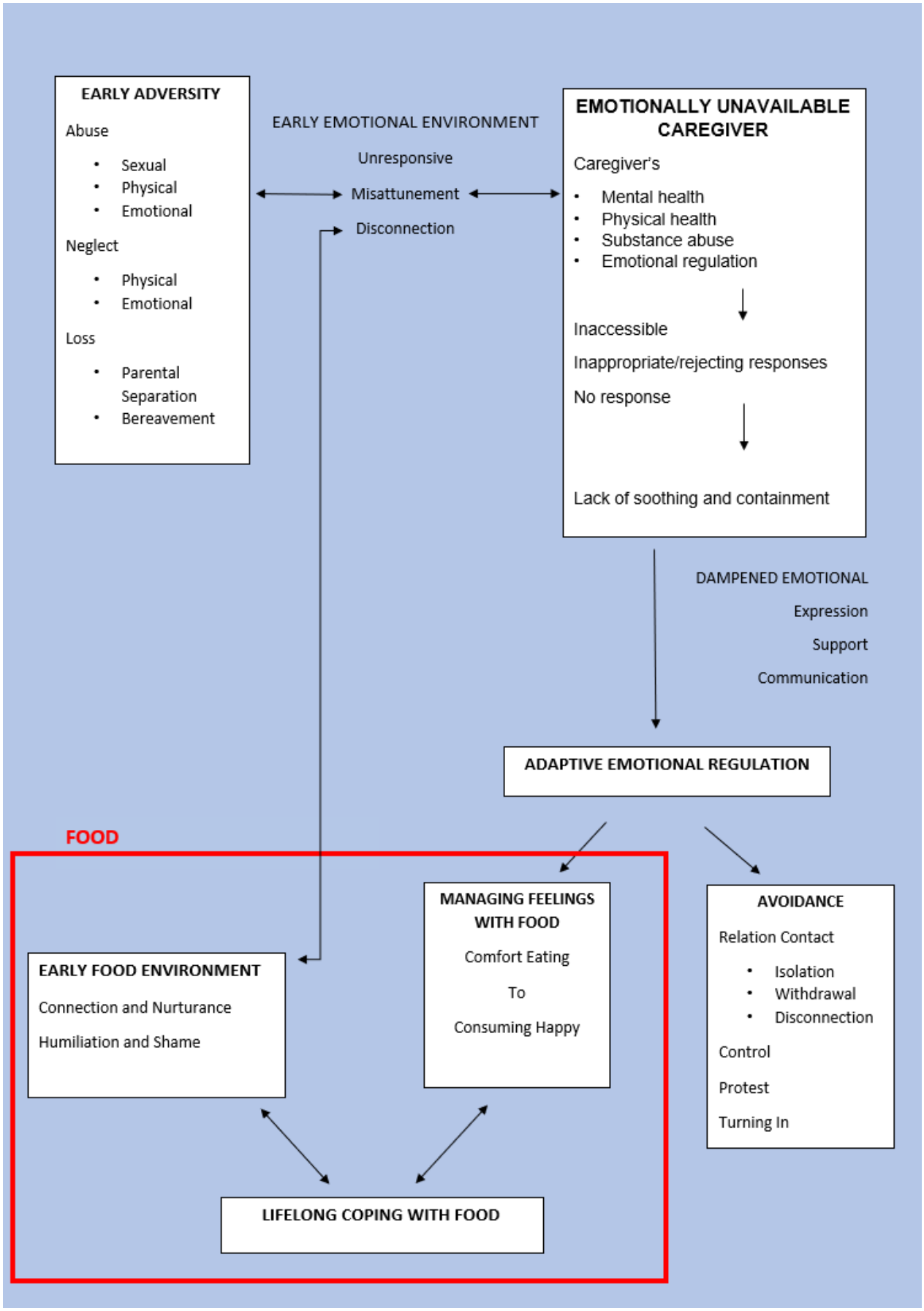
EARLY ADVERSITY
Abuse
Sexual
Physical
Emotional
Neglect
Physical
Emotional
Loss
Parental Separation
Bereavement
EARLY EMOTIONAL ENVIRONMENT
Unresponsive
Misattunement
Disconnection
EMOTIONALLY UNAVAILABLE CAREGIVER
Caregiver's
Mental health
Physical health
Substance abuse
Emotional regulation
Inaccessible
Inappropriate/rejecting responses
No response
Lack of soothing and containment
DAMPENED EMOTIONAL
Expression
Support
Communication
ADAPTIVE EMOTIONAL REGULATION
FOOD
EARLY FOOD ENVIRONMENT
Connection and Nurturance
Humiliation and Shame
MANAGING FEELINGS WITH FOOD
Comfort Eating
To
Consuming Happy
AVOIDANCE
Relation Contact
Isolation
Withdrawal
Disconnection
Control
Protest
Turning In
LIFELONG COPING WITH FOOD

Figure 1

6. Discussion

In this section I aim to present a relationally orientated, trauma-informed integrative understanding of the development of a multifaceted and complex relationship with food and ultimately the development fatness. This research proposes that early adversity laid the foundation for a maladaptive relationship with food in adulthood by compromising attachment and undermining the development of socioemotional skills; namely emotional regulation and the capacity for interpersonal connection and support, what we now know from neurobiological research are critical tasks of childhood (Siegel, 1999; Schore, 2012). I will explain and expand on the underlying processes involved in the emergence of the use of food for something more than physical fuel that is born from the negative impact of early ongoing stress on the developmental trajectory. In this perspective the body is not the problem; instead the body offers an insight into developmental trauma which is reflected through eating behaviours. The perspective developed through this research project will be discussed in light of relevant models that exist within the field of counselling psychology and psychotherapy, with key ideas drawn from developmental interpersonal neurobiology, which are helpful in making sense of the findings of this study by linking existing knowledge to explain the processes evident in the data. The results of this project will also be discussed in relation to the contribution to clinical practice and theoretical knowledge in the fields of counselling psychology, psychotherapy and healthcare.

6.1 Outline

The fundamental findings of this research are the existence of significant early and ongoing relational trauma. These exposures occurred most often within the child's caregiving system and included early loss, abuse and neglect. There was a prominent commonality across the trauma experiences that centred on a corresponding emotionally impoverished, unsupportive or inconsistent early environment; participant's narratives indicated that it was less about the event and more about the response to the event. What this research identified was developmental trauma; the cumulative effect of multiple ongoing traumas alongside emotionally unavailable, inconsistent and neglectful or absent caregivers. In the forthcoming section I will outline my proposal of how early ongoing stress of this kind impacts attachment and subsequently socioemotional development and the adaptive use of food.

Firstly, using relevant theory and literature, I will outline the link between the experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events most often of an interpersonal nature, attachment failures and impairments of the early development of the brain's stress coping systems (self-regulation) and how this in turn effects relational

competencies. Amid these challenging early environments were numerous and repeated prominent experiences around food and eating.

Two key processes around food will be discussed. Firstly, as a relational nurturing experience; food and eating act as a substitute for or aid to emotional nourishment, safety and belonging, becoming enmeshed within the attachment system. Secondly, I will outline the impact of developmental trauma and problems in the early family environment on socioemotional development, with the focus on the dispositional use of food as the main form of self-regulation. I will also propose an important difference in the generally accepted version of 'emotional eating' to 'consuming happy'. This concept may give a moment for pause both in clinical work and research, to consider the impact of early life history of the client. I will then turn attention to the ensuing lifelong relationship with food and eating and discuss the struggles with this highly complex and deeply emotive relationship.

This research demonstrated that for this group of women the process of weight gain was not a singular sudden event in which the relationship to food changes but rather a convergence of several processes within their early environments. The interaction of these systems creates conditions that promoted the emergence of an unhealthy yet adaptive food relationships, leading to a reliance on food for more than a physical fuel and nourishment but rather for managing intense affect while also securing a sense of connection and safety.

A focus on the body as the problem and the medical view of obesity as a calorie in calorie out formula, for this group of women, is negligible. The range and incidences of developmental trauma described in this research support recent research which has highlighted the long-term impacts of childhood adversities on morbidity and mortality in adulthood (Felitti, 2002; Anda et al., 2006; Danese & Tan, 2014) and relevant research associated with an elevated risk of developing obesity over the life-course (Williamson et al., 2002; Boynton-Jarrett et al., 2012; Norman et al., 2012; Afifi et al., 2017). By focusing on weight alone, these experiences of early life that have a profound ability to shape the individual across the life-course, would otherwise be missed. This research is important for clinicians in psychological and health contexts to consider the many complex factors that can contribute to weight related difficulties.

6.2 Developmental trauma

In response to my main research question the findings revealed that for some participant's childhood was a very violent time; for others childhood was permeated with loss, unpredictability, unresponsiveness and other forms of adverse developmental experience. These early experiences of abuse, loss, illness and neglect fell broadly in line with the rates of adverse childhood experience reported in previous findings (Felitti, 2002; Williamson et al., 2002). In this research it was not a single traumatising event but continual experiences of

abuse, neglect and loss within the primary attachment relationships that was emphasised. Within this context of ongoing trauma, the caregiver's emotional availability, specifically the quality of the attunement and responsiveness held most relevance for participants. Consistent misattunement without repair and consequently inadequate nurturing was highlighted. These results provide deeper insight into the impact of both normal developmental needs and traumatic experiences landing in a relationally impoverished or inconsistent environment. The dominant outcome was that participants felt inconsistent, unresponsive or punishing emotions from their caregivers during times of the most considerable stress or felt directly threatened and frightened by their caregivers. In this scenario the source of their comfort is their pain, or the source of their comfort added to their pain.

6.2.1 Attunement and development

Children learn to regulate their behaviour, emotions and cognitions through the experiences of their caregiver's responses to them (Schore, 2012). Key to this process is the caregiver's capacity for attunement; the ability to tune into the external expression of the internal states of a baby and respond appropriately to the child's emotional needs and moods. In other words, the process of giving complete, non-judgemental, responsive attention to the child through nonverbal forms of attention and response. In early life a child is fully dependent on caregivers to meet their needs. Experiencing frequent attunement is a basic need, essential to support healthy development. Not only does attunement provide grounds for the development of secure attachment between a child and a parent, it also supports the individual's sense of wellbeing and growth towards resilience (Siegel, 2010). A secure, responsive early relational environment helps nurture, educate, enrich and ultimately protect the life of a developing child.

In this study the data indicated that the primary caregivers were often too preoccupied, distressed, unpredictable, punitive, distant or absent to be reliably responsive. This type of ongoing stress (misattunement) without proper re-attunement deeply disturbs the capacity to experience being attuned to (Schore & Schore, 2008). When a child suffers consistent non-recognition and disconfirmation of their self-experience they become distressed easily and do not learn to attend to their own emotions and needs or learn to collaborate with others when their own internal resources are scarce (Cook et al., 2005). Prolonged or frequent episodes of unregulated distress sets the stage for an insecure attachment relationship leaving them vulnerable to further trauma and later psychiatric and psychosomatic disorders (Schore, 2003). Emotionally, the foundations for forming relationships, self-regulation and feeling safe and at rest in the world are damaged. This intersubjective failure of early attachment relationships, one of the foremost results in this research, is referred to as 'developmental trauma' (Van der Kolk, 2015) also termed 'relational trauma' (Bromberg, 2011). I will refer to developmental trauma as this term is increasingly used to conceptualise and describe early,

chronic trauma and there is an argument within the field to add developmental trauma disorder to the DSM.

6.2.2 Misattunement and adaption

The findings of this research support the concept that the receptiveness of the child's main attachment system is the most influential factor in healthy development, even in the face of multiple environmental challenges and trauma (Cook et al., 2005). Caregiver support and emotional functioning are critical mediators in normal healthy development and in determining how children adapt to adversity, abuse and neglect. In this research there was commonality of dysfunction across caregiver's responses including, non-recognition and a lack of involvement, impairment in validating the child's experience and reduced capacity in tolerating the child's affect. In addition, caregivers struggled with emotions themselves, often leaving them unavailable or prompting inappropriate responses. The results showed that in response to a global lack of environmental attunement participants did not learn to attune to their own needs, emotions and bodies. Unable to recognise and express their own needs, the ability to take in care and feel connected to others is limited. This was expressed in both the wish to be 'unseen' and the lament of being 'invisible'.

The findings indicated typical adaptions to these prolonged attachment and nurturing disruptions. Disconnection was prominent. This was evidenced by avoiding or suppressing their emotions, avoiding interpersonal connection or focusing on the needs and distress of the parent. The participants commonly became emotionally and socially inhibited, striving to avoid attention or connection.

These results suggest attention should turn to the role of early developmental trauma in persons struggling with obesity. This is placed within a wider burgeoning of interest in the negative effects of early developmental trauma on adult mental and physical health (Felitti, 2002; Edwards et al., 2003; Anda et al., 2006; Green et al., 2010; Norman et al., 2012; Luecken et al., 2013; Danese & Tan, 2014; Pignatelli et al., 2017; Afifi et al., 2017).

6.3 Socioemotional development

Early ongoing trauma leaves the child more vulnerable to poor psychosocial outcomes. In this section I will use existing theory and literature to outline how developmental trauma exposure and early attachment disturbances can result in struggles across several areas of functioning. Guided by the results of this study, I will discuss disturbances in self-regulation and the experience of interpersonal relationships.

6.3.1 The developing brain

There is consensus across psychological, psychotherapeutic and neuroscientific thinking that repetitive and sustained abuse and neglect is at the core of childhood trauma (Van der Kolk & Fisler, 1994; Siegel, 1999; Schore, 2003; Cicchetti & Toth, 2005; Cook et al., 2005). This vast body of research has consistently shown that traumatic childhood experiences are not only extremely common, they also have a profound impact on the physical, behavioural, cognitive, social and emotional functioning of children (Cook et al., 2005; Lucy-Dobson & Perry, 2010) and as noted earlier, an increased risk of various health and social problems across the lifespan. The reason that early developmental trauma is of such significance is that it occurs at critical times when the brain is most rapidly developing. It therefore can have a tremendously negative impact on experience dependant maturation of the neural systems involved in both relationships and the stress response (Schore, 2003; Schore & Schore, 2008; Schore, 2012). Considering the findings of this research through a modern attachment lens it is possible to explain how early developmental trauma compromised key tasks of development evident in this group of participants.

6.3.2 Co-regulate to self-regulate

According to modern attachment theory the caregiver-child relationship actually shapes the structure and function of the brain (DeKlyen & Greenberg, 2008; Schore & Schore, 2008). Schore proposed Regulation Theory to explain a key element of this process; the capacity to self-regulate i.e. the ability to flexibly regulate the psychobiological states of emotions through interactions with other humans (Schore, 2012). Through predictable, consistent, responsive emotional communication the infant's brain receives what is needed to develop the capacity for both healthy attachment and self-regulation capabilities. A growing body of research validates this theory indicating that our early relational experiences shape our neural architecture and ultimately the ability to regulate affective life (Tronick, 1989; Siegel, 1999; Beebe & Lachmann, 2001; Fonagy & Target, 2002; Gerhardt, 2004; Cozolino, 2006). Among this upsurge of research into early brain development there has been a focus on the effects of maltreatment on the developing brain during infancy and early childhood. Collectively this research has indicated that the brain's development can be physiologically altered if the caregiver is depressed, stressed, high, inconsistent or absent (Schore, 2012; Siegel, 2012). The reflecting back and modulation of an infant's affective state is important to their developing knowledge and mastery of their emotions and the sense of self (Stern, 1985). Without adequate co-regulation of infant distress states the autonomic nervous system and affect-regulating brain structures fail to develop optimally (Schore, 2003).The result is a child that is less able to manage emotional experience, more vulnerable to future stressors and less

capable of benefiting from the healthy nurturing supports that might help buffer stressors or trauma later in life.

Early attachment experiences influence the development of socioemotional processes that are central to the infant's experience of being in the world and the development of life-long coping capacities. This in turn affects self-esteem, self-control, future interactions with others, the ability to learn well and to achieve optimum mental and physical health and regulation skills (Schore, 2012). In short, attachment processes play a critical role in the development of many life-long coping capacities across the life span and lie at the centre of human experience that literally form who we are.

6.3.3 The signs of difficulties

The primary question of this research showed that the women interviewed encountered numerous traumas in their childhood. The data also indicated repeated failures and deficiencies in their attachment systems. Research has consistently demonstrated a connection between experiences of early childhood neglect, trauma, attachment failures and affect dysregulation (Van der Kolk & Fisler, 1994; Siegel, 1999; Ford et al., 2005; Schore, 2012; Van der Kolk, 2015). The basic hypothesis is that when we have not been appropriately soothed and have not had carers who have sufficiently helped us to manage feelings we are likely to have great difficulty managing them as we grow up in adult life (Buckroyd, 2011). Without consistent, predictable and nurturing caregivers to attend fully to these early affective states of distress developmental impairment of key skills and competencies arose.

Various problems with self-regulation were recognisable in the histories, current coping strategies, relationships and in the narrative styles of the participants. This was communicated through difficulties such as low self-esteem, being excessively independent or overly dependent and an aversion to physical affection. Social problems were also evident, namely the inability to develop and maintain friendships, aggression and violence, difficulty with genuine trust, intimacy and affection and alienation from parents, carers and other important figures. The propensity toward emotional and relational withdrawal was a key feature in all narratives, with all citing some version of '*having a wall*' or '*having one foot out the door*' of their primary adult relationships.

6.3.4 Avoiding emotions

The data indicated high levels of emotional avoidance to control intense emotional responses. The dispositional use of avoidant emotional regulation strategies was reflected in the narratives through impaired memory recall and a reduced ability to express specific and differentiated emotions. Emotions related to the events were frequently absent or very general, with reference to feeling bad, down or not good. The narratives were either quite stiff or there

was investment in shutting down the affective space with the intention of moving away from the topic. These difficulties suggest less emotional awareness and clarity (Van der Kolk & Fisler, 1994) making it a difficult task to sooth and regulate emotional responses and formulate effective response strategies. One participant succinctly commented *'half the time I don't know what I'm feeling or thinking, so I just avoid avoid avoid'*.

The ability to both express and regulate emotions in a socially and contextually appropriate manner is critical in encouraging positive social functioning and psychological adjustment in childhood and beyond (Eisenberg et al., 2007). Given that emotions were not accurately evaluated, flexibly communicated and effectively responded to, there was a tendency toward suppression, internalising and dissociation and hence an inhibition in seeking out support or contact in relationships. Avoidance of emotions, the body and relationally authentic attachments were primary in maintaining a sense of wellbeing and safety throughout childhood, adolescence and into adulthood. While avoidance of emotional states and inhibition of emotional expressivity are adaptive strategies in the short term, over time they can contribute to negative social consequences such as reduced personal connections and greater difficulties in forming relationships.

6.3.5 Avoiding relationships

Within the relational domain avoidance was associated with physical safety, emotional security and preserved a sense of personal control. This strategy was born from low expectations of the primary attachment relationships, expressed as a loss of trust in others and loss of the belief that they will be looked after and feel safe. Once you lose the expectation that you will be protected it is healthy to adapt accordingly. Relationships were organised around the expectation and prevention of rejection and abandonment.

The adaptive avoidant driven strategies employed were synonymous with poor emotional recovery from negative interactions which sustained rather than resolved disconnection. This was clearly seen in the primary attachment relationships where consistent misattunement lead to significant rupture without repair. These affective expectancies embedded in the attachment relationship showed up in less commitment in romantic relationships in adulthood (Simpson et al., 2011) and in less social support (few meaningful friendships). This seemed a self-perpetuating prophecy where the feeling of disconnection drove the need for reassurance and security. This in turn prompts an avoidant relational style, further fuelling the sense disconnection and lack of trust and ultimately leads to difficulties negotiating stable relationships with others over the lifespan.

6.3.6 Integrating theory

These findings are consistent with a vast body of research that argue that the most far-reaching effect of early developmental trauma is the loss of ability to regulate intense feelings and impulses and engage in fulfilling and meaningful relationships (Van der Kolk & Fisler, 1994; Schore, 2012; Luecken et al., 2013; Vajda & Láng, 2014). The modern attachment theory framework clarifies this connection between developmental trauma and subjective difficulties with emotional life and the associated problems in relationships. Focusing on the influence of the childhood family environment on socioemotional competence makes sense of the findings of this study. It also elaborates text in the eating disorders realm that propose emotional regulation is a mediating factor between adverse childhood experiences and the development of disordered eating behaviours (Pignatelli et al., 2017) and a more specific focus on emotional abuse and disordered eating behaviours (Vajda & Láng, 2014; Hund & Espelage, 2006). This important role of the attachment system, a complex yet fundamental process, explains why not all experiences of trauma or loss in early life transpire to impairments in socioemotional competence (Lucy-Dobson & Perry, 2010).

While these findings fall in line with a growing body of research showing a positive correlation between adverse child experiences and biopsychosocial health across the lifespan (Felitti, 2002; Hilgen Bryan, 2019) the obvious question that comes next is why food? What is the purpose of eating in relation to developmental trauma and reduced self-soothing skills? This research suggests that the participant's issues were both not about food and about food.

6.4 The inevitable choice of food

In this section I will outline the drive toward eating relative to developmental trauma, the attachment system and deficits in emotional regulation outlined above. Choosing food was not a singular or homogeneous process but a complex mix of factors that interweave and interact with each other. The relationship with food was primarily born from the emotional climate of childhood which was influenced by both absence and presence of nurturance and love, scarcity and fulfilment as well as fear and shame. It was also about the process of moving out of discomfort. In the absence of a consistent and predictable other to support co-regulation eating proved to be a very effective strategy to self-sooth and to alter affective states; food in effect became the co-regulator. Thus, attachment history is both experienced in and represented by the body. I will introduce the idea of 'consuming happy' in replace of emotional eating. Finally, I will outline the process of binge eating as a means of avoiding distress. Participants described binge eating as an automatic reaction, commonly to negative mood, with the expectation of the pleasure of eating overriding the knowledge it will also induce shame, guilt and remorse.

This research has strongly emphasised that food has layers of subjective meaning with their roots in the early experiences and corresponding socio-emotional environments. A central concept that was resoundingly expressed in the interviews was that all the participants understood their relationship to food and eating had history and meaning, rather than a simple calorie in, calorie out equation.

6.5 Feeding experiences

At its most basic level the fundamental learning of this research was that the participant's relationship with food and their patterns of eating were established in childhood. The findings suggest that the early attachment styles are mirrored in the relationship with food and the body. Being fed when you're hungry is one of the first ways we experience the world and trust and attach to our caregivers. Food was deeply associated with the presence of meaningful contact within the attachment system and sense of belonging within the family system. These positive experiences around food were imbued with both physical *and* emotional nourishment in an environment of emotional scarcity. Early experiences of safety, fulfilment, nourishment and belonging were closely tied to food and are no easy task to separate. However, early contradiction muddied these waters. Early experiences around food also involved fear, abuse, insecurity, neglect, inconsistency and this showed up in eating patterns and the ongoing relationship with food.

A significant authority to the later relationship with food was the family atmosphere around mealtimes. These narratives fell into two broad groupings. I will firstly discuss those that were positive and exuded a sense of nourishment and enjoyment. In this realm, eating became an effective way of meeting their needs for a safe, warm, accepting and loving connection to their caregivers. Next, I will discuss early experiences around food and feeding that were negative, focusing around humiliation and punishment, which usually resulted in efforts to 'subterfuge' eating. The associated shame that permeated into the experience of eating is a key element in the evolving phenomenon of 'secret eating' which was a precipitating factor in later binge eating.

6.5.1 Emotional nurturance

Familial and cultural traditions of food and mealtimes are related to both family functioning and wellbeing. The multi-layered activity of eating holds deep symbolic meaning for its members that informs the emotional quality and meaning of food (Fiese et al., 2006). The findings of this research indicated that in emotionally impoverished environments, one of the main sources of positive relational interactions, were based around food and mealtimes. A warm and connected emotional atmosphere surrounding food in early life provided predictability, reassurance and security. Participants indicated a significant connection between caregiving

and feeding practices and while this was particularly emphasised by those who identified a parent as obese, it was quite prevalent across most interviews. Southwell and Fox's research (2011) with mothers of obese children showed that providing food was a means of providing care and thereby fuelling the desire to be a good mother. Caregiving through the means of food, was seen in various formulae throughout participant's stories from using food to comfort, reward or treat and at times as a basic tenant of the relationship. This type of emotional feeding seemed to be used as an interpersonal strategy wherein care is provided through food.

What this research indicates is that participants responded to this emotional feeding. The strongest element of the food-caregiving link appeared to be emotional nurturance rather than physical nourishment. Eating was the filling station for love, acceptance and security. In an atmosphere of emotional scarcity, fear and inconsistency, participants often felt cared for, safe and connected in the presence of familiar and nourishing setting of family mealtimes or food-based interactions. This emotional filling up was an adaptive and very effective way of getting their needs met and formed a significant part of the early experience with food. Food is a container both for memories of positive experiences of comfort and shared enjoyment with caregivers and a substitute for unmet developmental needs of connection and security.

Put differently, food had a relational intimacy function with an underlying implicit meaning of providing care and communicating love. This emotional nourishment through food along with the traditions and predictability around mealtimes provided a sense of security, acceptance and belonging to the family. Food and mealtimes symbolised being cared for along with a togetherness and warmth and eating an adaptive way to feel close to caregivers, providing a sense of love and connection in a usual environment of emotional scarcity, uncertainty or loss.

The commonality was that food compensated for unmet developmental and emotional needs in the caregiving system. This is a significant finding of this project that separates early positive experiences with food from the usual celebratory or comfort function within the familial and cultural system. This important distinction in the use of food has been highlighted in previous qualitative research where it was noted that "eating became a substitute for belonging rather than a celebration of being together" (Goodspeed Grant & Boersma, 2005, p. 219). When food acts as a substitute for attachment needs it garners great meaning and power. If you felt insecure, fearful, sad or responsible with your caregivers but felt safety, comfort and joy with food or a secure connection with caregivers through food, this explains why one might struggle with overeating or binge eating. Taking this strand of the food relationship alone from a wider framework of complexity it is unrealistic to expect to change the relationship with food with lifestyle advice or behavioural intervention alone.

6.5.2 The shame of food

The findings revealed that in all cases the relationships with food were not static and changed over time dependent on personal, familial and social experiences. The ensuing food relationship developed complex and layered meanings early on. The enjoyable and positive experiences with food offered a safe haven in difficult environments. However, there was also paradox around food and mealtimes born from shame experiences, explicit and implicit mixed messages around food and teasing around the use of food, either from inside or outside the home. It was both a source of emotional nourishment, security and connection and a source of fear and deep humiliation. There was a broad range of examples of this humiliation, from the abusive hostility from a stepfather *'you greedy pig'*, to the underhand message *'oh my new wife is so beautiful and thin, she doesn't eat'* to the more elusive everyday comments from family *'oh I can't keep her fed'* along with painful singling out and teasing from peers.

The result appeared to be the symbolic association between food and humiliation which became internalised and was voiced in a sense of shame for being defective, worthless or unlovable to others. A common experience that speaks to this shame was the need to hide from 'the gaze' directed at either the body or eating behaviours. This was the case even when what was described was either normal, healthy eating behaviours e.g. asking for fruit in between mealtimes. Or familial encouraged ways of using food evident when caretakers were identified as feeders. This stresses the importance of the relationship to food rather than the food itself. The anxiety around both spending time with abusive caregivers and the judgement and humiliation that often presented at mealtimes makes sense of struggles with eating around others. This was especially true when the underlying emotional scarcity is experienced in the sense of never having enough and food as a means of responding to this gap. The instinct to avoid gaze prompted the practise of 'secret eating' which started with hiding normal and accepted eating behaviours (with their associated underlying meanings and emotional fulfilment).

A similar process that prompted a further stark contradiction to be integrated into the food relationship was when food, was used as both a reward and punishment. An important factor to note is that what was identified as 'punishment' using food was emotional abuse masquerading as punishment in response to either very small misdemeanours, or more often, a reaction to the child's normal limitations. These assaults presented a similar predicament; shame and fear permeating a medium that at other times brought security, enjoyment and connection. This contradiction seems to have been internalised into a sense of their connection and enjoyment of food being 'wrong'.

6.5.3 The problem of contradiction

These contradictory relational experiences set up an incomprehensible paradox. How does the relationship with food remain uncomplicated when it is fused with both love and shame, security and fear? What meanings can we understand when participants describe sneaking apples or hiding quite ordinary eating behaviours? What happens when a caregiver and feeder suddenly degrade previously encouraged and endorsed eating behaviours? In short, food did not remain clear and simple but was fused with fear and confusion, becoming a double-edged sword driving shame and withdrawal where it otherwise brought connection and security. These are the contradictions that are being wrestled with in a social context that demands food, for the obese population, be a simple formula. Rather than a focus on the body, the goal needs to shift to heal the relationship with food, which calls for a consideration and relational understanding of early attachment and trauma.

6.6 Emotional eating

Emotional eating is conceptualised as eating in response to negative affect. It is widely accepted that emotions influence eating behaviours, evidenced by recurring scenes in media when someone (particularly a female) is sad or stressed and is shown consuming far more food than is physiologically necessary. This is reflected in everyday life with the use of comfort foods, which is not only a normal behaviour, but often central to cultural traditions to support distress, e.g. in response to loss. In other words, there is a recognised normative level of emotional eating in response to life events and their emotional consequences (Waller & Osman, 1998).

Research has consistently shown that food reduces negative affect and is used as a coping strategy to manage stress (Slochower et al., 1981; Larsen et al., 2006), with individual differences in how stress impacts food selection (Oliver & Wardle, 1999; Zellner et al., 2006). Moreover, studies indicate that healthy, normal-weight individuals regulate negative emotions by eating (Macht & Simmons, 2000; Macht et al., 2005; Macht, 2008). We know that negative emotions increase food consumption, both for normal weight and overweight people. However, it has been shown that the influence of emotions on eating behaviour is stronger in obese people (Canetti et al., 2002). The findings of this research support the evidence linking emotional dysregulation to problematic eating patterns and behaviours in an obese population (Gowey et al., 2016). The data showed that across the board participants described routinely and significantly increasing their food intake and the likelihood of overeating or binging, during times of high emotional arousal and stress. This was illustrated repeatedly by participants referencing '*eating the feeling; eat to calm; comfort eating; eating when happy; celebrating means eating;* '*I eat when I'm down*; *stress eating'* all of which can be understood under the umbrella term of emotional eating.

In this project all the women self-identified as emotional eaters and reference consistently using food to 'medicate', consistent with the literature linking negative mood and stress with eating (Smyth et al., 2007), along with lesser researched area of eating in reply to positive mood (Bongers et al., 2013). A common thread was having limited or unpredictable interpersonal emotional support, no one they could turn to, so they turned to food. Without a conscious awareness eating quickly developed into an effective strategy to cope with negative affect and as a result they often engaged in emotional overeating.

While the connection between emotional eating and obesity is not linear and simplistic, it has been generally accepted for some years that emotional eating is used to self-medicate and self-regulate mood (Thayer, 2001). In response to the argument that a lack of specificity of emotion inhibits detailed study of the psychological precursors to overeating (Arnow et al., 1995) attention turned to an exploration of the specific emotional/mood states associated with emotional eating.

6.7 Consuming happy

An important and nuanced finding of this research was that participants did not emphasis the emotional state (often struggling to identify and express specific emotions as discussed above) that triggered overeating. Nor did they refer to eating to sooth or comfort, the generally the accepted goal of emotional eating. Instead they referenced eating as a method to move out of negative and into positive affect. Eating became a way not only to comfort 'bad' mood but to ameliorate it, replace it quickly with feeling good. This was described in the frequent assertions e.g. '*It made me feel good; I feel good when I eat; it makes me happy; my happy place'*. The consistent focus on the enjoyable aspects and positive mood following emotional overeating seemed counterintuitive as I had expected to hear about guilt and regret that often follow significant overeating. The key aspect of this experience was that rather than a comforting and soothing of distress, there was a move into a different affective state, identified as 'good' or 'happy'. This was especially clear in childhood but also remained a factor in their eating experience (especially binge episodes) as adults.

I propose that rather than emotional eating, what these participants described was a process of 'consuming happy'. This is an important distinction as it alludes to the power of eating in solving the problem of uncomfortable emotions. In expecting to hear about negative-based states following eating I had not considered the impact of the developmental stage at the genesis of emotional eating. What became clear was that a fundamental factor of 'consuming happy' was its timing. The process of eating emerged as a leading emotional regulation strategy early in childhood. This before fully grasping the impact of food on the body and before shame-laden food experiences flooded the system. Learning to alter affect states with

food early in development predisposes a likelihood of overeating and weight gain. I suggest that in attempting to clarify the psychological precursors of emotional overeating and binge episodes, future research should consider the history of the emergence of this strategy rather than focusing on the activating emotional states alone. This approach encompasses a consideration of the relationship with food and hence incorporates attachment and trauma histories, along with other important socioemotional factors.

The maintaining factor of 'consuming happy' was the enjoyable, feel good function of food. Participants appeared to channel their emotional life through food, especially as an effective means to promote a positive affect state, thereby associating eating as a highly enjoyable experience. Integrating a neuroscientific perspective of the stress reducing and pleasure inducing effect of food on the brain, offers a biological underpinning that may in some way explain the powerful result of this process.

6.8 The neurobiology of food

Across the medical context there is a focused effort to explicate the underlying biological processes involved at the interface of eating and emotion. Within the brain specific areas play a major role in regulating eating behaviour such as those involved with homeostatic sensing, emotion, reward-motivation and executive-control (Burghardt et al., 2015). Research has indicated that individuals with obesity demonstrate distinct brain activity patterns that promote a heightened response to food stimuli and less control overeating behaviour (Gosnell B, 1990). Obese populations have also been found to have a distinct hormonal profile that influence feeding behaviour (Anthony et al., 2006).

Given the proposed link between rising obesity rates and the obesogenic food environment, several studies have investigated the biological basis of energy dense food such as sugar and fat (usually consumed in emotional eating and binge episodes) in promoting positive affective responses. Dysfunction of the reward system in the presence of highly palatable food has become a major focus of research in discerning the biological basis of obesity. A recent systematic review and meta-analysis of human studies "support that altered general reward-related decision making is a salient neuropsychological factor across eating and weight disorders in adulthood" (Wu et al., 2016, p. 177).

The dopamine pathway is thought to play a primary role in the reward system. Although the precise involvement of dopamine in the reward system is still unclear most researchers agree that it is involved in feeding behaviour. Human studies using neuroimaging determined that obese patients had dysfunctions in the dopaminergic system and one hypothesis proposes that obese subjects compensate for this dysfunction by overeating palatable foods (Wiss et al., 2018).

The endogenous opioid system has long been known to regulate food and energy balance particularly by moderating consummatory behaviour beyond satiety (Berthoud, 2002). An opioid-mediated dependence on sugar has been demonstrated at both the behavioural and neurochemical level in studies with rats (Colantuoni et al., 2002) and human research has linked the endogenous opioid function with obesity (Burghardt et al., 2015). Additionally, the opioid system is involved in the regulation of affective and stress responses and is therefore positioned as a common mediator that underlies the interface of food intake, pleasure seeking and emotional regulation (Burghardt et al., 2015). Furthermore, both under and overfeeding in childhood have the potential to increase obesity prevalence through the dopamine and opioid systems (Grissom & Reyes, 2013) and such effects have been observed at the intergenerational level (Vucetic et al., 2010).

The biological based food addiction framework for understanding obesity is the notion that highly processed 'hyper-palatable' foods have hijacked the reward centres in the brain (Wiss et al., 2018). This suggests that highly processed foods are addictive and pleasure-seeking pathways may play a critical role in the pathogenesis of obesity (Lee & Dixon, 2017) along with other individual factors such as hormonal regulation of metabolism (Camacho & Ruppel, 2017) and gut microbiome (Aguirre & Venema, 2015).

However, the medical perspective attempts to explain obesity mostly from a biological stance. Taking a biopsychosocial approach, the assumption that biochemistry, genetics and other biological based explanations, drive eating behaviour can be incorporated into a wider consideration of complex and inter-related factors.

Considering the data from this perspective, having limited options for self-regulation, born from difficulties in the early socio-emotional environment coupled with a very effective tool to move out of distress into feeling 'good', as evidenced at a biological level, it is a big challenge to not use food. Nevertheless, the findings of this research suggest that the process 'consuming happy' to self-regulate, although adaptive and helpful in the short term, also appears to be an antecedent for binge behaviours in this participant group.

6.9 Binge eating

All participants struggled with binge eating which this population described as a quick development from what I coined as 'consuming happy'. Participants reported a steady increase in the frequency, quantity and intensity of eating, resulting in a typical binge experience which was labelled accordingly as a *'binge mode; a binge; eating and eating'*. While feeling good or happy was still identified during and after a binge, as time passed the emotional atmosphere of a binge elaborated to include the characteristic experience of feeling

out of control and the emotional responses of guilt and remorse. Despite the known contradiction, the primary trigger of a binge episode was to emotionally regulate.

In the eating disorders context, there has been an increasing interest in the role of emotional regulation in binge eating disorder (BED) and as outlined in the literature review there is substantial empirical support for a direct link between emotional dysregulation and binge eating. Those with BED report greater difficulties in emotional regulation compared to individuals without an eating disorder (Kenny et al., 2017; Eichen et al., 2017). Binge episodes are regarded as an attempt at emotional regulation of negative affect, albeit maladaptive, by providing momentary relief from aversive emotions or inducing pleasure (Safer, 2015). The literature pertaining to BED is particularly relevant for obesity because BED is associated with an increased risk for obesity (Grilo, 1998). Although you can be obese and not have BED or have BED and not be obese. While none of the participants have reported having a BED diagnosis, they all reference a serious ongoing (or very recent) struggles with binge eating making the literature relevant for this study.

The emotional regulation model has been adapted to explain binge eating (Safer, 2015) and the theory suggests that individuals with BED experience difficulties regulating emotions and consequently turn to binge eating in an attempt to influence, change or control painful emotional state. Furthermore, because they turn to food consistently, they develop a low expectancy for being able to self-soothe in any other way other than through using food i.e. the individual learns to expect relief from negative affect by eating. This may also be affected by biological processes in the reward system of the brain as outlined above. These eating expectancies become automatic thereby strengthening the association between eating and perceived control over emotions, all of this happening within the 'obesogenic' environment. Hayaki (2009) argued that this negative reinforcement of eating expectancies, driven by experiential avoidance of negative affect, could be included under a global inability to regulate negative emotional experience.

Consistent with this theory, there were many examples in the data of binge eating to avoid emotional experience or induce positive feeling and thus regulate emotions. The data showed that an identified generic negative mood often preceded binge eating, along with a vivid impulsivity in turning to food. All participants firmly understood their binge eating as a virtually automatic reaction, commonly to negative mood, with the expectation of pleasure overriding the knowledge it will also induce shame, guilt and remorse.

Avoidance of affect is positively associated with unhealthy eating attitudes (Corstorphine et al., 2007). The findings of this research support the evidence which suggests that women who binge eat are more likely to report higher levels of emotion intensity, lower acceptance of

emotions, less emotional awareness and clarity and are more likely to engage in maladaptive regulation strategies compared to individuals from a healthy control groups (Corstorphine et al., 2007; Svaldi et al., 2012). These findings have been replicated in non-clinical ED sample where greater difficulty in identifying and making sense of emotional states along with limited access to emotion regulation strategies predicted binge eating (Whiteside et al., 2007). A central finding in this research which is consistent with this key theory in the eating disorders context is that participants displayed difficulties with self-regulation with deficits in key skills and a dispositional reliance on avoidant emotional regulation strategies. As previously discussed, there were various incidences throughout the interviews that indicated difficulties with awareness and acceptance of emotions. In addition, described were difficulties accessing adaptive emotional regulation strategies when experiencing negative emotions with a heavy reliance on food and eating, including both the process of 'consuming happy' and further along the scale, binge eating.

The findings of this research support the theory that a deficit in skills required to adaptively and effectively cope with negative affective states gives rise to an increase in binge attacks (Svaldi et al., 2012). The use of food and binges to regulate negative affective states extends to a non-clinical population, i.e. those who have not been diagnosed with BED, are obese and struggle with binge eating.

In this study the relationship with food, involving of number of complex process, appears to be, at the very least, one of the main factors in developing and maintaining increased body weight across childhood, adolescence and adulthood. The findings indicate that the relationship with food is far more important than the food being eaten, although this does also play a significant role. The meaning of food and the relationship to it is a complex system of multidimensional and iterative processes that intertwine and mutually influence each other within the context of the attachment system.

6.10 The dark side of the moon

All the participants spoke about their lifelong struggles with their weight. For most, weight was the foremost issue in their life. They had all attempted numerous diets. They had listened to and taken the sanctioned medical and health advice on board to no avail. The most problematic and socially sanctioned consequence of a complex relationship with food that underlies weight gain, is that the being fat becomes the problem and the focus. This distracts from the difficulties and impairments in emotional regulation, interpersonal relationships and complex trauma histories as well as the experience of living in a fat body. Felitti described this focus on weight as the tackling 'smoke' rather than the 'fire'.

A pervasive problem with weight loss is the promise of happiness and acceptance that a thin body brings. With conventional and endorsed weight loss, the goal is a number on a scale with the implicit promise of a happier, more successful and healed life. What is not on the agenda is the underlying trauma or acknowledgment of the potentially vital role of food and eating for basic functioning for a significant number of fat people. It is fair to say that all these participants either suffered significant loss or came from troubled homes which equated to a high prevalence of trauma in their childhood. Yet common societal judgement would have us believe that weight is their biggest issue and the unspoken promise that once the goal is reached, then '*you actually start to live'.* This research strongly backs the long standing argument that the societal, medical and individual focus on weight to the exclusion of anything more "provides a convenient and culturally reinforced distraction from the reasons why so many people use food when they are not hungry" (Roth, 1992, p. 4).

A focus on weight loss alone sets up a one-sided, unwinnable battle. Until there is an understanding and healing from developmental trauma and other strategies learned to replace eating as a means of emotional regulation, they are stuck; a catch-22. Losing weight is the goal, weight loss is achieved through changing their eating behaviours. However, changing their eating behaviours leaves them at the mercy of unregulated emotional experiences, an exposure of the body and a departure from feelings of connection and security, treading perilously close to early trauma. This unsurprisingly prompts a return to the most effective emotional regulation strategy and position of safety, eating. In addition, they are shamed. Shamed because their bodies don't fit with societies expectations. Shamed because losing weight is a simple formula. Shamed because they should be able to do it.

> *That's constantly how I'm feeling now about my weight loss journey whatever you want to call it, I actually feel really ashamed of myself that I haven't done better, that I should have done better*

If you strip away food and eating the most effective emotional management tool is gone, along with a tried and trusted way to feel connected and secure. For people whose struggle with weight is ongoing and painful, it is likely that food has been a lifelong way of coping and eating a necessary element in their functioning. It is unlikely that this will be given up until it is acknowledged and other strategies are learned. The task will involve finding other ways to self sooth, to learn to '*to feel hunger and process things while hungry'* along with advances in body esteem and self-confidence. This involves not only finding other, better ways of managing their feelings before surrendering eating behaviours, but also understanding their habitual relational dynamics expressed through food and the body and an avoidance of relational intimacy. What

is unlikely to help for this population who have significant trauma and impaired self-regulation is a focus on weight loss alone.

In this study, at the individual level, there was varying levels of awareness of this impossible paradox. Some were turning attention to the relationship with food rather than weight. While for most there was ambivalence and confusion about what this meant; one participant was working to not only accept her fat body but also to process emotions away from food. This allowed her not only to see food differently but to use it differently which, accordingly, had associated weight loss. Others were starting to appreciate their difficult relationship with food was not exclusively tied to their body. This was highlighted when a vast reduction in body weight (after bariatric surgery) did not remedy the emotional reliance on or appetite for food, or when weight gain and loss was tied to abusive relationship patterns.

While there was a grasp of a more complex relationship with food that was impeding weight loss, many participants were enrolled in typical weight loss programmes or by default were focused on weight reduction, possibly due to a combination of the pressure to conform to dieting culture and a lack of other options. However, without attention on this wider understanding of their vast histories and meanings of food, the same old weight loss advice resulted in the same old predicament; tripping at the last hurdle of weight loss goals and a returning to long term and trusted eating habits. These women were not only exasperated and tired, but also frustrated with losing the same battle and the feeling of not quite '*getting it*' which spoke to the early feeling of '*never quite having enough*', linked to deficits of emotional nurturance in the early attachment system.

When fat is the designated issue and society endorses it, shame sends the real issues to the dark side of the moon. The early relational trauma; abuse, neglect and loss and the emotional reliance on food to function. In addition, the continued forceful judgement and discrimination that are experienced by those who live in a fat body, remain out of sight and out of mind. I suggest that rather than focusing on changing a fat body, what is needed is acceptance of the fat body. In this study fatness was a symptom of much bigger fundamental problems with living; how to live with complex trauma, process emotions and learn to fully engage in intimate and authentic relationships.

7. Reflections on relational ethics issues

There are many dimensions of ethical responsibilities throughout the research process. As discussed earlier, the learning offered from my initial rushed recruitment efforts, opened my eyes to some of the realities of living in a fat body and promoted a more compassionate approach where I held concern for my participants at the forefront of the research process. This approach is discussed through the building rapport and trust with my participant's and reflections on participant's involvement past the interview.

Once participants expressed interest, a lot of groundwork was done in order to prepare for the interviews, moving beyond procedural concerns such as informed consent and confidentiality to my primary concern for my participant's wellbeing. This involved planned time with as much space and contact as the participant needed to consider the potential experience and impact of an interview. This resulted in numerous potential participants deciding not to take part but also I believe, built a foundation of trust that allowed for an authentic, mutual interaction between myself and my participants. This again was highlighted in opting for phone interviews which required me to place my concern for my participants and their desire to go ahead with the interview, above my control over data collection.

Given the emotional nature of the project and considerable trauma revealed, I was aware that the interview process required a balancing act between the wellbeing of the participant and facilitating disclosure. Ellis describes this moving back and forth between disclosure and restraint as "dialectical oppositions" (2007, p.20). During the interviews, staying close to difficult material and emotion with empathic responses often facilitated expression. While opportunities to push for further information presented during interviews, particularly with sudden changes of subject or quickly glancing over questions, I followed my participant's lead of what they were comfortable discussing, therefore delineating the difference between a singular interview and a therapeutic relationship. Respecting both the participant's capacity to discuss their traumatic experiences and also following their lead within the discussed aims of the project facilitated the balancing act between the 'intensive interviewing' that Charmaz (2006) calls for and protecting the participant from undue harm. All my participant's expressed a positive experience of the interview in the debrief and most significantly appreciated the space and interest in their story rather than their body.

I offered my participants to be involved in the research process as much as they wished to be. From the outset, some participant's indicated that they were interested in telling their story and the possible benefits of the interview experience. In these cases, following the debrief with agreed contact around progress and sharing the final project, their felt a natural closure of the research relationship. Two participants were students themselves and said they were also

interested in reviewing the results, however one did not read the material and the other didn't offer any comment on the information shared, instead saying she was interested to see the process. This may have been in part due to the extended time period between interviews and completed data analysis. While I was still engrossed in the data in the months and years after interviews, they are likely to have moved on from the interview.

On reflection of the interview process and communication with all my participants, the feedback centred on their experience of telling their stories, without the focus on their body or encouragement around weight loss. While my motivation for the project was explore and understand the possible impact of childhood experiences on obesity, my participant's motivation was to take up my invitation to tell their story.

8. Contribution and applicability

I believe that the most important contribution of this research is that it shifts the attention from the body to the person. As noted earlier, obesity is a global and rising epidemic and the sheer volume of research and intervention that focuses solely on weight, rather than attempts to understand the individual, is quite staggering. Conversely, this research offers a relational, trauma-informed understanding of subjective experiences that contributed to the relationship with food (and ultimately the development of fatness), which makes this research project one of the rare attempts to fill this gap in the field of obesity research.

8.1 Clinical implications

The results of this study lend support to the association between traumatic experiences in childhood, attachment difficulties, compromised emotional regulation skills and obesity in adulthood. Successful treatment will therefore depend on addressing the psychological consequences of adverse experiences and circumstances in early life. These findings indicate the necessity for the clinician to have a solid theoretical understanding and clinical sensitivity toward attachment history, developmental trauma and their consequences along with the benefits of psychotherapeutic interventions. Efforts to support the integration of underlying trauma and address attachment related problems may yield increased effectiveness in therapy, independent from potential weight loss goals.

In a trauma-informed approach early work should focus on establishing a secure relationship and a sense of safety for the client. Attention is focused on helping the client discover their inner resources encouraging the reduction of avoidance and the development of other self-soothing strategies. Rothschild commented that a trend in trauma treatment seems to overemphasise the method and underemphasise the therapeutic relationship. Relationally orientated, trauma-informed therapy requires a delicate balance, attending to the explicit level of helping the client to learn and improve self-soothing skills and the implicit level attending to relational dynamics, experiences of attunement and interactive regulation. The goal of therapy is to increase the capacity to sustain stability and to experience joy with self and others by supporting the individual in the emotional, cognitive, physical, spiritual and social aspects of wellbeing and health. This perspective understands and emphasises how traumatic experiences can impact development over the life course and is sensitive to how this may relate to a person's current health behaviours and health status. Clinicians therefore need relevant training and experience to flexibly engage with theoretical knowledge to tailor to the needs of the client.

Moreover, given that trauma and attachment processes are implicated in the relationship with food, I suggest that clinicians should consider the emotional ties and potential nurturing

function of food. Asking about early relational experiences and exploring the family atmosphere around food may help to better understand and appreciate the individual's relationship to food and eating. For example, in this study food was experienced as emotional nurturance in early life which highlighted deficits in the attachment system. Adult attachment style, in particular avoidance of relational intimacy, set the stage for food to continue to hold this function, impeding trauma recovery and making weight loss unlikely.

Similarly, clinicians should also consider the protective benefits of obesity which can lead those with abuse histories, either consciously or unconsciously, to gain and retain weight. When obesity is a protective mechanism weight loss may feel physically or sexually threatening (Felitti et al., 2010) and therapists will need to address this barrier. I suggest that weight loss should not be the presumed goal of therapy or indeed medical treatment and instead the aim should be an integration and acceptance of the body and the internalisation of a sense of safety and connection to oneself and others.

The results of this study call for relationally orientated, trauma-informed therapy, highlighted by the prevalence of trauma and attachment processes in the development of a complex relationship to the self, others and to food. Developmental trauma positions relationships as double-edged; trauma stems from them and recovery cannot happen without them.

Future interventions, both preventive and healing, should be developmentally informed and trauma sensitive. With a deeper understanding of the individuals experience we can offer improved support and avoid unnecessary and inappropriate interventions. This is equally true for the medical context as much as for psychological services.

8.2 Service provision

A significant percentage of obese patients presenting to primary care for treatment or support in relation to their weight may have trauma histories. This research challenges the general guidance within the NHS that all obese individuals can be understood in the same way and given the same lifestyle management advice. It is vital for health care providers to view individuals from a trauma-informed perspective to guide best practice, because when you understand trauma, you understand behaviour. This could start with the simple shift in perspective from 'what's wrong with you' to 'what happened to you' or simply 'why'. Routine screening for childhood adversity, which has been found to reduce subsequent GP visits (Felitti, 2012), could be incorporated into the NHS and could potentially yield a more inclusive understanding of the patient, their eating and their specific needs. Understanding that health conditions and harmful health behaviours although medical problems, from the patient's perspective may be solutions to overwhelming emotions from life experiences (Felitti et al., 2010), allows for a more sensitive and tailored treatment. This research suggests that this

should include trauma-informed psychological therapy for weight-related health, in addition to the current treatment pathways offered by the NHS.

In addition, the same considerations could be adopted by treatment programs aimed at those with disordered eating, overweight and obesity. Such programs might consider the possibility of trauma histories to identify individuals who could benefit from trauma-informed psychological therapy.

Trauma-informed obesity treatment approaches warrant research to assess their relative effectiveness against traditional treatments for weight-related problems. A holistic approach to the success of these treatment programmes could also be broadened to include patient's emotional wellbeing, mental health and relationships rather than their weight alone which provides only a one-dimensional view of health and the individual.

Prevention or early intervention strategies would be the most desirable approach for reducing trauma related poor mental and physical health outcomes, including obesity. The first step of prevention strategies is the dissemination of knowledge. Education of primary health-care providers, educators, childcare providers and public health officials of the trauma–obesity connection may yield more understanding, appropriately tailored treatment options and sensitive and timely referrals. Knowledge of the trauma-obesity link may help those best placed in identifying and working with at risk families. This could play a role in preventing maltreatment related to obesity and/or reduce the impact of traumatic experiences by referring families to social services and community resources that reduce future trauma risk, improve attachment relationships and ultimately aid in psychological recovery.

9. Strengths and future research

One of the strengths of this research is that by looking at a problem differently it becomes a different problem. Turning the attention away from the body and weight and onto early experience provides insight not only into the complexities of the individual relationships with food but also the prevalence of the interplay of attachment processes, early trauma and key socioemotional skills. Integrating the findings of this research with contemporary attachment theory elaborates the connection between adverse early experiences and obesity. This research also opens a new area of understanding of why eating has a more commanding emotional resonance for some, which challenges the idea that weight loss through restriction 'should' be about willpower and determination. This relationally orientated, trauma-informed integrative understanding of the development of a multifaceted and complex relationship with food and ultimately the development fatness, refutes the view of obesity as a personal and even a moral failure.

There are areas within this research that warrant further study. As noted earlier, research aiming to explicate affect states that trigger emotional eating would benefit from widening the focus to include the roots of the phenomenon; when, how and why it developed would offer further elaboration around the meaning of emotional eating rather than the procedure alone. This is especially important if there is difficulty in recognising or expressing specific emotions.

Furthermore, redefining the design of the study to include other methods could produce a more in-depth exploration of new insights of this research. For example, further investigation into the similarities and differences between 'emotional eating' and 'consuming happy' might help understand different processes at play and whether divergence has any significant bearing on the evolution to binge eating. This could therefore inform more suitable and tailored interventions and prompt further research.

To make this research more valuable, further research to substantiate the findings could be conducted on a larger scale, potentially through NHS services for obesity, or community-based weight loss services. A larger sample and more diversity in sex, race, socioeconomic status and environment could validate or dispute the findings of this research.

My main proposal for the future direction of research or interventions endeavouring to understand or 'treat' obesity is that attempts should be made to understand the differences within the obese population by considering what the relationship to food might indicate. Rather than using categorisations to separate (e.g. BMI scores / BED and non-BED) ACE scores, Adult Attachment Interview and measures of, or reported struggles with, emotional eating and binge eating (not exclusive to diagnosis) along with qualitative methodologies, in particular interviews or group settings, might prove more useful. Both quantitative and qualitative

methodologies could capture both prevalence and experiential meanings. Any individuals who have strong emotional ties to food, use food for self-regulation or where weight is protective, warrant a psychologically informed approach to both research and treatment.

Extending the finding outside of obesity, evidence demonstrating the relationship between exposure to childhood adversity and adult health outcomes continue to grow (Kalmakis & Chandler, 2015). A recent study, replicating previous findings, found that a patient with an ACE score of 6 or more is 24-times more like to attempt suicide than a patient with an ACE score of 0 (Merrick et al., 2017). In addition, the risk for depression, drug and alcohol use triple with ACE exposure. This highlights the importance of the healthcare system to recognise the role of psychological adversity and reinforces the recommendation of a trauma-informed approach to overall health and well-being.

9.1 Methodological benefits and limitations

The main benefit of using a qualitative study is that this approach allows for an in-depth and experiential account of the phenomenon under study. By using a small-scale study with interviews, the data is composed of subjective experiences and the results convey both an in-depth and nuanced view of the processes at play and the voice of the participants.

Conversely, the main disadvantage of qualitative approaches and the most apparent limitation was the small size of the study. As with any small study the findings cannot be extended to wider populations. This study focused on exploring an under-researched area in an effort to propose a new understanding rather than to test whether results are statistically significant or due to chance.

This study does not propose that all women who are obese use food for emotional purposes or that the roots of their obesity can be traced to early adversity, affect dysregulation and attachment difficulties. A decision to interview those individuals who had reflected on the influence of their childhood on their weight was made in order to explicate an understanding of the psychological and emotional components involved for that specific population. This was an intentional recruitment decision in order to fill in the gaps in the literature. Future research focusing on the psychological and emotional factors influencing weight might include samples who do not consider their childhood as important or those who did not experience significant adversity. Exploring the relationship with food from different perspectives might advance our understanding of the phenomenon and complement the relational, trauma-informed understanding presented in this research.

10. Conclusion

This research project has enabled me to put forward a relationally orientated, trauma-informed understanding of obesity. The emphasis of this perspective is on the relationship to food rather than the body. This relationship was informed by several complex and iterative processes. These included the life alerting influence of developmental trauma, attachment patterns and early social experiences and meanings around food. I propose this perspective as an expansion to, rather than a replacement of, the acknowledged interaction of biological, social, economic and environmental factors.

The contribution of this research project is in directing attention to the individual and their psychology rather than the body. Allowing for a relationally orientated, trauma-informed perspective of obesity opens new avenues of research and possible treatment, along with empathy and understanding on an individual level. This strengthens the argument for working with early material as a means of healing and growing the relationship with the self and others, improving the capacity to self-regulate and ultimately transforming the relationship with food from the main source of calm and security. This in turn may lead to the goal of common obesity treatments, successful and sustained weight loss.

This research is a call for dismantling the discrimination and prejudices held against fatness that conceal trauma; efforts should now turn to treating the fire rather than the smoke. The careful consideration of an individual's life and history when tailoring treatment, as a basic standard of care, is likely to be more effective than doling out the same lifestyle advice which has proven to be ineffective on an individual and societal scale (Wing & Phelan, 2005; Tsai et al., 2005). NHS strategies aimed at obesity treatment and prevention should develop guidelines that considers pathways beyond diet and activity, specifically looking at developmentally informed, trauma-sensitive psychological interventions.

The findings of this study indicate that the notion that all overweight people need the same advice is flawed at best and is driving deep prejudices which are harmful to fat individuals physically, emotionally, socially and economically. These women had a rich tapestry of stories and backgrounds with profound examples of abuse and neglect in their histories. These varied and complex individuals were fighting to find a secure place within themselves, their bodies, their relationships and their worlds and deserve access to compassionate and informed healthcare. Rather than grouping these women together with others of the same body size, for the purposes of informing them that they are fat and need to lose weight, I propose that the basic care and understanding afforded to thin people is extended to the fat population.

This research invites us to move away from focusing on symptom reduction, in this case body weight reduction, to consider the ways that the symptoms reflect both the internal and the

relational struggles that these women encounter. Understanding obesity through attachment, trauma and regulatory systems involves a paradigm shift away from the traditional understanding and intervention of obesity at the behavioural level. The challenge, in a body phobic system, is to shift the focus from what the body weighs and turn attention to what the body is communicating about what it means to be alive. Effective treatment should recognise the interface between eating, attachment and trauma and work to cultivate the neuropsychological and relational structures that support the ability to regulate emotions, connect with other humans and ultimately thrive in the world.

Look at a problem differently and it becomes a different problem. What if, instead of trying to locate a problem within the individual, that we are curious? What if we try to understand the relationship with food and eating, what it means, how it developed and what it offers? What if we offered exploration, understanding and support? What if we look at the person rather than their fat?

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12. Appendices

Appendix I – Advert Letter Hard Version

Childhood experiences of women who are currently classified as 'obese'.

The aim of this research is to explore childhood experiences of women who are currently classified as obese to try to understand the nature of the problem of obesity in relation to personal history or psychological influences.

This study is being conducted by Brigid Carley (supervised by Prof. Julia Buckroyd) as part of research towards a Doctorate. The study has been approved by the Metanoia Research Ethics Committee. Participation is confidential.

Can I take part?

- You can participant in this research if you are female and
- Currently classified as obese with a BMI of 35 or above.
- You have struggled with dieting / behavioural interventions.
- No previous psychological therapy in relation to your weight issues.
- No organic medical issues that have caused your weight difficulties.

What is involved?

If you decide to take part, you will be asked to participate in a one to one interview at a convenient time and location for you. The interview will last between 1-1 ½ hours and will be audio recorded. You will be given time at the end to talk with the interviewer about the interview and ask any questions or further comments without being recorded.

During the interview you will be asked about what childhood experiences you consider important in your life experience. The aim of the interview is to allow you to tell the story of your childhood so I will ask in detail about important experiences, your thoughts, feelings, beliefs about these experiences and what impact they have had on you.

How do I take part?

Participation is voluntary and you may withdraw at any time up to publication. All of the information you give is anonymous, will remain completely confidential, and will be used for the purposes of this study only.

If you think you meet the criteria and are interested in taking part or have any questions about the study you are invited to contact me via phone/email to discuss further.

Brigid Carley

Email: brigid.carley@metanoia.ac.uk

Appendix II – Advert Letter Online Version

Appendix III – Participant Information Sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET (PIS) AND CONSENT FORM

You will be given a copy of this participant information sheet and a signed consent form to keep.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

Currently obesity is viewed as a behavioural/environmental problem without any reference to personal history or psychological influences. The relationship between obesity and life experience is virtually never considered. It is viewed as a condition simply to do with lifestyle and practical choice, reducing a serious international health problem to a simple matter of behaviour and willpower.

The aim of this research is to explore childhood experiences of women who are currently classified as obese to try to understand the nature of the problem of obesity.

Why have I been chosen?

My aim is to interview women about what they considered as important childhood experiences. You have been asked to participant if you are

Currently classified as obese with a BMI of 35 or above.

- You have struggled with dieting / behavioural interventions.
- Age of onset was early adulthood.
- No previous psychological therapy in relation to your weight issues.
- No organic medical issues that have caused your weight difficulties.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive from the agency / person who provided this information.

What will happen to me if I take part?

If you think you meet the criteria and are interested in taking part or have any questions about the study, we will arrange a telephone conversation to discuss further.

If you decide to take part, you will be asked to participate in a one to one interview at a convenient time and location for you. The interview will last between 1-1 ½ hours and will be audio recorded. You will be given time at the end to talk with the interviewer about the interview, ask any questions or provide any further comments without being recorded.

What do I have to do?

During the interview you will be asked about what childhood experiences you consider important in your life experience. As far as possible, conversations about weight will be kept to a minimum to avoid the pull towards focusing solely on your weight. The aim of the interview is to allow you to tell the story of your childhood so I will ask in detail about important experiences, your thoughts, feelings, beliefs about these experiences and what impact they have had on you.

What are the possible disadvantages and risks of taking part?

It is possible that talking about your life story can bring up some distressing memories or you may become upset. There will be time to debrief after the interview and if you feel you need support, I will supply a list of agencies and therapists that you can contact.

What are the possible benefits of taking part?

I hope that participating in the study will help. Sometimes talking about experiences can give insight into your current life and help you deal with your problems. However, this cannot be guaranteed.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with the Data Protection Act UK (1998).

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the Metanoia Research Ethics committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

What will happen to the results of the research study?

The results of the research will be published as part of my doctoral dissertation; however, all identifiable information will be removed (i.e. your name/others names will be anonymised and not appear anywhere in the document).

The dissertation is likely to be published. You will be able to obtain a copy of the research from the British Library or alternatively I can send you a copy. A summary of the research will also be posted on the BEAT website.

Importantly you will not be identified in any report/publication.

Who has reviewed the study?

The Metanoia Research Ethics Committee have reviewed and approved this study

Contact for further information

Researcher

Name: Brigid Carley

Email: Brigid.carley@metanoia.ac.uk

Supervisor

Name: Prof Julia Buckroyd

Address: P.O Box 1074, St Albans, AL1 9RH

Email: julia@juliabuckroyd.co.uk

Finally

Thank you for considering taking part in this study

Appendix IV – Consent Form

CONSENT FORM

Participant Identification Number:

Title of Project: Childhood experiences of women who are currently classified as 'obese'.

Name of Researcher: Brigid Carley

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐

3. I understand that my interview will be taped and subsequently transcribed. ☐

4. I agree to take part in the above study. ☐

5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

Appendix V – Example of open coding

Project: Research DCPsych

Report created by BCarl on 22/10/2019

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6 IN006 – Selection of Document

6:21 Eh as a kid, my family didn't hug, no one really if your upset you get…… (6862:7165) - D 6: IN006

Eh as a kid, my family didn't hug, no one really if your upset you get on with it, you go into another room and you get over it you just get over it [okay] that's how my family deals with things you get over it, if your ill you take paracetamol you get over it [em], laughs, it's just what they are like

2 Codes:

- Emotionally unavailable caregiver / - Family emotional disconnection

6:22 So if something happens that upsets you, you don't talk about it [no n…… (7167:7442) - D 6: IN006

So if something happens that upsets you, you don't talk about it [no no no] you just kind of isolate yourself, manage the emotion and get over it?

Yeah

So is that what you think you did as a child?

Yeah defiantly you just never spoke about it [voice goes into a whisper] [em]

1 Codes:

- Emotional avoidance

6:23 well I think it obviously did because the way I have been the last few…… (7489:7840) - D 6: IN006

well I think it obviously did because the way I have been the last few years like I've been really really ill with depression [em] and anxiety and things like that [em] and its cause I wasn't used to saying how I felt like [said through laughter] and its only been really this last year that my Mum has actually found out that it's not okay [laughs].

1 Codes:

- Identifying own vulnerability

6:24 Even now like if my sisters are upset then we just can't deal with it…… (7935:8067) - D 6: IN006

Even now like if my sisters are upset then we just can't deal with it like [said through laughter] we find it really awkward [em] so

2 Codes:

- Emotionally unavailable caregiver / - Family emotional disconnection

6:25 Em I think when my Mum and Dad split up for the first time, I was So w…… (8396:8568) - D 6: IN006

Em I think when my Mum and Dad split up for the first time, I was

So when you were six?

Yeah so my little sister was four [em] and I remember my Mum just crying constantly

1 Codes:

- Parental Separation

6:26 Yeah so my little sister was four [em] and I remember my Mum just cry…… (8484:8708) - D 6: IN006

Yeah so my little sister was four [em] and I remember my Mum just crying constantly and then before I know it my Dad was outside school and he picked us up and he bought us both chocolate [laughs] and a Steps video [laughs]

1 Codes:

- Managing feelings with food

6:27 we find out that he had another partner, and I knew it would hurt my M…… (8817:9200) - D 6: IN006

we find out that he had another partner, and I knew it would hurt my Mum if she found out so I kept it to myself for ages [em] I really did,

What was that like to keep that secret? I don't know it was easier, my little sister was just four and she ended up saying something [laughs] I mean she wasn't sophisticated enough to say 'hi mum Dads not in' she just said 'Dads girlfriend'

2 Codes:

- Developmentally inappropriate responsibilities / ● Keeping secrets

6:28 my Mum found out that way but even then we were like just say nothing…… (9211:9303) - D 6: IN006

my Mum found out that way but even then we were like just say nothing [em] just say nothing

1 Codes:

- Emotional avoidance

6:29 What were you worried would happen if you did tell her or she did fi…… (9468:9733) - D 6: IN006

What were you worried would happened if you did tell her or she did find out? She would just cry again [laughs] and then every time she would cry as a kid I would cry. Like I don't now but for a really long time if she cried I would cry [em] I didn't even know why

2 Codes:

- CG emotional dysregulation / ● Identifying own vulnerability

6:30 Yeah so she would get in her car and go out, obviously not when we wer…… (9921:10152) - D 6: IN006

Yeah so she would get in her car and go out, obviously not when we were six [yeah] but as we were older she would get in her car and go out and that's what I learned to do if I'm upset I will go in my car and I will drive off [em]

1 Codes:

- Emotionally unavailable caregiver

6:31 I'll just park somewhere and cry because I don't want anyone to see me…… (10200:10330) - D 6: IN006

I'll just park somewhere and cry because I don't want anyone to see me cry. Its cause I don't want anyone to ask how I am [laughs]

1 Codes:

- Invisible emotions

6:32 I just don't want to talk about it to be fair [said in a whisper]. It'…… (10380:10682) - D 6: IN006

I just don't want to talk about it to be fair [said in a whisper]. It's different if like I know they are part of the community mental health team but it's different if like the nurse rang me [em] I would tell her but not if its someone who's close to me [em] she was removed from the situation [okay]

1 Codes:

- Emotional avoidance

6:33 Just awkward, I just can't do it. Can you say more about it being awk…… (10790:10939) - D 6: IN006

Just awkward, I just can't do it.

Can you say more about it being awkward? It's just something my family don't do, we don't open up. None of us do.

1 Codes:

- Family emotional disconnection

6:34 But there are ways of acknowledging something is wrong like isolate yo…… (10941:11272) - D 6: IN006

But there are ways of acknowledging something is wrong like isolate yourselves or like you Dad if he has some upsetting news he buys some chocolate?

Yeah he'd take us out for dinner, or take us to McDonalds or always food, always [em]

So that's the way you learned to,

Yeah so if I'd had a bad day I'd go and buy chocolate [em].

1 Codes:

- Managing feelings with food

6:35 So instead of my Dad waking up when the twins cried at night, even at…… (11979:12174) - D 6: IN006

So instead of my Dad waking up when the twins cried at night, even at eight years old, I'd be propped up on my Mums bed with a baby and a bottle cause she couldn't feed them both at the same time.

1 Codes:

- Developmentally inappropriate responsibilities

6:36 My Dad was just not interested [em] he has never been interested in b…… (12176:12303) - D 6: IN006

My Dad was just not interested [em] he has never been interested in being a Dad, like he was there, but he was never interested

1 Codes:

- Emotionally unavailable caregiver

6:37 even at eight years old I remember holding the twins [laughs] half asl…… (12308:12520) - D 6: IN006

even at eight years old I remember holding the twins [laughs] half asleep in the middle of the night [em] just feeding them and ever since it's been the same like I've been the twins second Mum not there sister.

1 Codes:

- Lack of Recognition

6:38 Yeah some bits are good [yeah] but it has been the most stressful thin…… (12563:12916) - D 6: IN006

Yeah some bits are good [yeah] but it has been the most stressful thing ever [em] because especially when they kept splitting up all the time like I was only nine and the second time especially was really hard cause Mum had to work to keep us I had to pick them up from school, take them to school [exhales] just do everything that a Mum was meant to do

1 Codes:

- Developmentally inappropriate responsibilities

6:39 Yeah completely, like it affected my A levels everything. (13045:13102) - D 6: IN006

Yeah completely, like it affected my A levels everything.

1 Codes:

○ Impact of early caregiving

6:40 No not until I was diagnosed with OCD and I had a massive breakdown [l…… (13190:13266) - D 6: IN006

No not until I was diagnosed with OCD and I had a massive breakdown [laughs]

1 Codes:

● Being noticed through illness

6:41 Oh I just wanted my Dad to step up I just wanted him to have the initi…… (13891:14309) - D 6: IN006

Oh I just wanted my Dad to step up I just wanted him to have the initiative [em] like even growing up from like eight to 17, I kept having to tell him to do things and like instructing him how to pick up the twins [em] and how to be a Dad [said through strained laughter] I just wanted him to do what Dads did but he never did. Or I just wanted my Mum to have time off work so I could go and do stuff I wanted to do.

1 Codes:

● Protesting - Silent

6:42 I just wanted him to do what Dads did but he never did. Or I just want…… (14164:14410) - D 6: IN006

I just wanted him to do what Dads did but he never did. Or I just wanted my Mum to have time off work so I could go and do stuff I wanted to do.

And what kind of things did you want to do?

Eh gosh…

Just normal kid stuff?

Yeah. I had them a lot.

1 Codes:

- Failure to promote child's social development

6:43 I think when all that happened as well they were like 'you need to tel…… (14412:14743) - D 6: IN006

I think when all that happened as well they were like 'you need to tell them, you need to back off a little bit'. It's only been the last couple of years that I've backed off a bit and that's been really hard because the twins would come to me [em] they would never go to Mum and Dad if something was wrong. They would come to me.

1 Codes:

- Assigned family roles

6:44 I do have a good relationship with my Mum [yeah] but she is more like…… (14917:15149) - D 6: IN006

I do have a good relationship with my Mum [yeah] but she is more like a friend [em] to be fair but I get really really annoyed with her [laughs] like I feel like I'm her Mum sometimes [em] cause I just can't see where her heads at

1 Codes:

- Parentified child

6:45 I don't have a relationship with my Dad at all now [okay] I haven't sp…… (15154:15246) - D 6: IN006

I don't have a relationship with my Dad at all now [okay] I haven't spoken to him in a year.

1 Codes:

- Relational Withdrawal

6:46 He left, us again, and he had just moved in like he was living at his…… (15266:15632) - D 6: IN006

He left, us again, and he had just moved in like he was living at his Mum and Dads house and [em] coming round and he was working but my Mum wanted him to move in [em] and none of us wanted him home cause we knew as soon as he came home, he'd have to leave again and I didn't want that to happen to the twins, like I didn't want their lives messed up like mine was

2 Codes:

- Inconsistent caregiver / ● Protecting siblings

6:47 like I didn't want their lives messed up like mine w (15579:15630) - D 6: IN006

like I didn't want their lives messed up like mine w

1 Codes:

- Identifying own vulnerability

6:48 yeah it happened he left and he got with someone else straight away so…… (15645:15786) - D 6: IN006

yeah it happened he left and he got with someone else straight away so he'd obviously been seeing this person [em] while he was with my Mum.

1 Codes:

- Parental Separation

6:49 I just think I like, I don't have a relationship with him I've never h…… (15907:16081) - D 6: IN006

I just think I like, I don't have a relationship with him I've never had any relationship with him [em] so I don't like I can't attach an emotion to it, it's really bad but.

1 Codes:

- Relational Withdrawal

6:50 Yeah definitely like the 2nd time they split up when I was 17 Mum came…… (16594:16837) - D 6: IN006

Yeah definitely like the 2nd time they split up when I was 17 Mum came into my room before it all happened and she was like 'I need your permission to be able to split up with him because for me to split up with him you have to have the twins'

1 Codes:

- Developmentally inappropriate responsibilities

6:51 Yeah definitely like the 2nd time they split up when I was 17 Mum came…… (16594:17101) - D 6: IN006

Yeah definitely like the 2nd time they split up when I was 17 Mum came into my room before it all happened and she was like 'I need your permission to be able to split up with him because for me to split up with him you have to have the twins' And I was like, what a question, why would I ever say no just split up with my Dad [em] obviously I had some feelings but I didn't think that was fair I didn't think she should have come into my room and be like 'well it's up to you if I split up with your Dad'

1 Codes:

- Developmentally inappropriate responsibilities

6:52 I just felt like I got the blame like it was my fault that they spilt…… (17107:17552) - D 6: IN006

I just felt like I got the blame like it was my fault that they spilt up [em] but the twins were 9 weren't they so I had to take on a lot of responsibility it was the only way we could get through.

And you didn't talk to anybody at the time about how you felt? You just swallowed your feelings?

Yeah I didn't really think about it properly, I don't know. Like I was upset for two weeks and stayed in my room and I didn't speak to my Dad again

1 Codes:

- Internalising blame

6:53 but the twins were 9 weren't they so I had to take on a lot of respons…… (17186:17306) - D 6: IN006

but the twins were 9 weren't they so I had to take on a lot of responsibility it was the only way we could get through.

1 Codes:

- Developmentally inappropriate responsibilities

6:54 Yeah I didn't really think about it properly, I don't know. Like I was…… (17405:17516) - D 6: IN006

Yeah I didn't really think about it properly, I don't know. Like I was upset for two weeks and stayed in my room

1 Codes:

- Invisible emotions

6:55 I didn't speak to my Dad again but eventually I did speak to my Dad ag…… (17522:17682) - D 6: IN006

I didn't speak to my Dad again but eventually I did speak to my Dad again because my Mum and Dad made up but you know this time, I will never speak to him again

1 Codes:

- Relational Withdrawal

6:56 I just can't be bothered. My birthday for example he just put a card o…… (17747:17902) - D 6: IN006

I just can't be bothered. My birthday for example he just put a card on the porch and put £100 in [laughs]. That's it like we just don't have any emotions.

2 Codes:

- Family emotional disconnection / - Lack of interest/action

6:58 Yeah I don't know [said though a whisper]. I kind of just avoid things…… (18337:18543) - D 6: IN006

Yeah I don't know [said though a whisper]. I kind of just avoid things I really do and that's why I haven't spoken to him so I don't have to deal with it [em] I know eventually I've got to deal with it but

1 Codes:

- Emotional avoidance

6:59 So your Dad was around in the beginning and he used to use things to t…… (18679:19030) - D 6: IN006

So your Dad was around in the beginning and he used to use things to treat you [yeah] but there wasn't a real connection. [No] You never remember spending time with, talking with your Dad? No even, I just felt awkward being in the same room with him [em] I just didn't know what to say to him. Like we are really different people, even as a kid like.

2 Codes:

- Emotionally unavailable caregiver / - Strained early relationship

6:60 Yeah which was just very difficult cause the way he was brought up he…… (19069:19341) - D 6: IN006

Yeah which was just very difficult cause the way he was brought up he would deal with everything with like, if someone picked on you at school for example he would be like 'punch them' [laughs] that's how he would deal with things [em] or you know grades aren't important

1 Codes:

- Parental encouragement of bad behaviours

6:61 He wanted a boy and he wanted them to be a 'boy' Okay, do you feel th…… (19542:19686) - D 6: IN006

He wanted a boy and he wanted them to be a 'boy'

Okay, do you feel that was an issue? Yeah he always wanted to boy, always, always wanted a boy.

1 Codes:

- Feeling undervalued

6:62 No. I was defiant. I didn't want to be like him I didn't want to be li…… (19908:20140) - D 6: IN006

No. I was defiant. I didn't want to be like him I didn't want to be like his family. I was snobby if anything [laughs] I really was. Cause I want more like I want to do more I wanted to mix with people who were like nice people and,

1 Codes:

- Denying father

6:63 No I mean no like we always knew he wanted a boy but there was not a l…… (20649:20973) - D 6: IN006

No I mean no like we always knew he wanted a boy but there was not a lot we could do about it [em]. It's a joke in the family. My sister is quite tomboyish the second one [yeah] so she was kind of his boy [laughs] and they are really close, they have a good relationship, the one down from me they have a good relationship.

1 Codes:

- Assigned family roles

6:64 I don't know like I don't know just my family and the way they show fe…… (21504:21736) - D 6: IN006

I don't know like I don't know just my family and the way they show feelings just aren't normal [em]. Like she trust me and with money and stuff like we help each other out with money and we are like friends [em] it's really hard.

1 Codes:

- Emotionally unavailable caregiver

6:65 Cause I couldn't deal with her and I didn't want her, there. Cause I j…… (21959:22312) - D 6: IN006

Cause I couldn't deal with her and I didn't want her, there. Cause I just feel awkward around her if I'm ill or I don't want her there [okay] so my best friend came with me. Even today when I've got my endoscopy like I asked her if she can pick me up but asked all of my friends can they pick me up before [laughs] cause I did not want her there [em] so

1 Codes:

- Family emotional disconnection

6:66 There is something really big about being vulnerable in front of your…… (22314:22594) - D 6: IN006

There is something really big about being vulnerable in front of your family that is a big no no for you?

Yeah completely.

You know it begs the question as to why that is, it feels dangerous?

Yeah I'll avoid it at all costs [laughs]

Was there ever a stage when you were? No. No.

1 Codes:

- Avoiding risk

6:67 Yeah like even when I was in therapy and having every week with the ps…… (22664:23026) - D 6: IN006

Yeah like even when I was in therapy and having every week with the psychologist like obviously you cry because they bring everything out of you [yeah] and I'd hate it like, look what you have done to me. I'd look like this and I would have to drive around until my face went normal [em] so that if you go home… but em I'm always the person who sort things out.

1 Codes:

- Feeling exposed

6:68 It's very uncomfortable for you to be in the other position because th…… (23028:23705) - D 6: IN006

It's very uncomfortable for you to be in the other position because that's always been your role, the one who sorts it out and you have been your mothers support [yeah] and you have been the one who tried to motivate your father to be a Dad

Emhmm, yeah.

Sounds like it's been,

You don't really think about it do ya [laughs] but

Is it hard for you to think and talk about it?

It's not the norm is it? It's not like I haven't spoken about it before so it's not anything new but yeah. When you saw the psychologist what was it like to talk? I know it's difficult to be vulnerable but did it give you any relief at all, did it help you understand? I refused to talk about it.

1 Codes:

- Repression / Distraction

6:69 I refuse to talk to anybody like I've been in therapy for so many year…… (23720:24189) - D 6: IN006

I refuse to talk to anybody like I've been in therapy for so many years and I'd refuse to talk to them cause they'd just go like in the NHS they'd just go like you would find another job, so you would trust someone then they'd leave [em] so I was like what's the point in me putting my trust into you and they you leaving [laughs] [em] so what's

the point. But then I got to the point with my psychologist where she was like, I am not going to leave, and she was good

1 Codes:

- ○ Level of trusting in relationship

6:70 Yeah, yeah. So trusting people is an issue then. Yeah I never trust a…… (24376:24452) - D 6: IN006

Yeah, yeah. So trusting people is an issue then. Yeah I never trust anyone.

1 Codes:

- ○ Level of trusting in relationship

6:71 Trusting people with your emotions anyway. Yeah. I can trust people w…… (24454:24579) - D 6: IN006

Trusting people with your emotions anyway. Yeah. I can trust people who have no idea who I am more than people who I do know

1 Codes:

- ● Feeling exposed

6:72 So do you think any of this impacting your relationships with food, I…… (25014:25356) - D 6: IN006

So do you think any of this impacting your relationships with food, I mean your emotions if you weren't talking about them? Just eat [em] and it generally made me feel good and it still does. And all my family do it and my sisters picked up on it. We go to the shop and buy loads of food and just eat it all.

It makes you feel better?

Yeah.

1 Codes:

- ● Eating to feel good

Appendix VI – Examples of focused coding

Project: Research DCPsych

Report created by BCarl on 22/10/2019

Code Report - Selected codes (6)

- **Managing feelings with food**

15 Quotations:

1:30 So what did you do with all of those feelings and thoughts? Em do you…… (7579:7753) - D 1: IN001

So what did you do with all of those feelings and thoughts?

Em do you know at that time I think what I did was just put them into my my food and my you know my starving myself

1:63 I I hated myself, which I couldn't understand at sixteen you know what…… (17476:17814) - D 1: IN001

I I hated myself, which I couldn't understand at sixteen you know what's going on here em but I had this loathing for myself and I wanted to lose weight and I think because I didn't know how else, and I've learned now, I didn't know how else to channel my feelings it just became like a project to put all your attentions into your food em

1:87 So was it at the time that this conversation got started about a poten…… (28053:28405) - D 1: IN001

So was it at the time that this conversation got started about a potential engagement where you still in a place where you were using food in the way you were?

Yeah yeah definitely I was very I was six stone and that was through eating an apple a day

Okay

You know I used to on my way to school I used to trip cause I'd fall down because I was so weak.

2:7 Okay, and what kind of impact do you think that had on you? Em I defin…… (2296:2399) - D 2: IN002

Okay, and what kind of impact do you think that had on you?

Em I definitely comfort ate from a young age

3:22 So how did you learn to deal with that feeling or what did you do with…… (9851:10147) - D 3: IN003

So how did you learn to deal with that feeling or what did you do with that feeling?

Em [laughs] I mean looking back I think I ate that feeling em [okay] sixth grade is really when I started I would come home and I would just binge on food I would just eat and eat and eat and then eat some more.

4:46 Yeah you know I ate [okay] I ate [laughs]. Yeah I ate a lot and I lear…… (17325:17431) - D 4: IN004

Yeah you know I ate [okay] I ate [laughs]. Yeah I ate a lot and I learned that you know mostly from my Mom

4:66 Em so how did you handle that stress I probably still ate you know I r…… (23972:24219) - D 4: IN004

Em so how did you handle that stress

I probably still ate you know I really didn't have that much outlets at that time you know I didn't do I didn't have anything extracurricular I didn't have any hobbies so of course yeah I just ate a lot of it.

4:114 I was in this programme and the first thing I recognised was about how…… (40271:40421) - D 4: IN004

I was in this programme and the first thing I recognised was about how I ate and how it affected my core ability to have emotions and to deal with life

5:127 Em we hid food constantly me and my sister now when I think about it a…… (46130:46582) - D 5: IN005

Em we hid food constantly me and my sister now when I think about it as well we'd sneak apples you know you'd find under our beds was just apple cores [mm] you know Mum had a drawer, there was a drawer in the house and it had crisps and do you remember the small snack type wafers snack biscuits you know the purple ones

[yeah] those types breakaway and things [yes yes] they were our, for our lunch boxes [mm] I remember we would sneak things like that

6:7 In my family, everybody is chocolate and cake mad; if you're sad or if…… (2823:3028) - D 6: IN006

In my family, everybody is chocolate and cake mad; if you're sad or if you're celebrating or if you're bored then buy a cake [yeah] and like that's how people celebrate and do anything really in my family.

6:26 Yeah so my little sister was four [em] and I remember my Mum just cry…… (8484:8708) - D 6: IN006

Yeah so my little sister was four [em] and I remember my Mum just crying constantly and then before I know it my Dad was outside school and he picked us up and he bought us both chocolate [laughs] and a Steps video [laughs]

6:34 But there are ways of acknowledging something is wrong like isolate yo…… (10941:11272) - D 6: IN006

But there are ways of acknowledging something is wrong like isolate yourselves or like you Dad if he has some upsetting news he buys some chocolate?

Yeah he'd take us out for dinner, or take us to McDonalds or always food, always [em]

So that's the way you learned to,

Yeah so if I'd had a bad day I'd go and buy chocolate [em].

6:110 So food is used to celebrate and to cope with a different range of emo…… (3031:3199) - D 6: IN006

So food is used to celebrate and to cope with a different range of emotions?

Yeah the first thing we will do is go to the shop and buy food [em] it's just how we do it.

8:1 Yeah it was you know and around then I started to you know use my pock…… (313:664) - D 8: Interview 7

Yeah it was you know and around then I started to you know use my pocket money and stop at the shop on the way home from school and I knew there was no one at home and it started small, a couple of small 10p bars and I would forget about

everything else and what child doesn't like chocolate right? It was my favourite part of the day when I could eat.

8:11 5 What was that like for you? (feeling unloved because of her father's…… (1150:1718) - D 8: Interview 7

5 What was that like for you? (feeling unloved because of her father's absence?) Oh, you know, terrible, awful…. em and I comfort ate, just small things at for a while…. em…but it didn't really take so long for it to escalate you know I was eating lots of rubbish, you know I would come home and eat and eat and eat. And other times, parties and things, I always asked for more cake, was constantly sneaking sweets and asking for more. I just wanted to eat…. em…and you kind of just don't recognise it as eating too much cause I just liked it you know, it felt good.

- **Relationship with food**

11 Quotations:

3:60 Right yeah. I don't remember food at all prior to my em eleven twelve…… (32913:33185) - D 3: IN003

Right yeah. I don't remember food at all prior to my em eleven twelve years of age [yeah] I don't there is no recollection of food good or bad I don't have any recollection of [emhmm] not getting food or liking food or anything like that until this age that [okay] so yeah

3:78 Yeah and I know that going into the surgery [yeah of course] em you k…… (41923:42179) - D 3: IN003

Yeah and I know that going into the surgery [yeah of course] em you know I felt the surgery would give me that extra push and tool that I needed em and so far it has em but I definitely need to figure out the relationship I have with food and work on that.

4:115 I recognised was about how I ate and how it affected my core ability t…… (40314:40676) - D 4: IN004

I recognised was about how I ate and how it affected my core ability to have emotions and to deal with life and I got into the programme because I – I realised I couldn't stop eating I had a moment where I just realised I had no fucking control over my eating I was eating constantly and I couldn't stop even though I had some sort of feeling of wanting to stop

4:117 I couldn't possibly be a restrictor because I'm overweight I struggle…… (42266:42466) - D 4: IN004

I couldn't possibly be a restrictor because I'm overweight I struggle with that all the time to own you know I have restricted and sometimes I still do restrict and it has nothing to do with my weight

5:131 Analogise when it comes to food, 'well you stop eating a certain food…… (48007:48419) - D 5: IN005

Analogise when it comes to food, 'well you stop eating a certain food you know it's the same thing if you were an alcoholic you wouldn't drink you know'. It's not the same. It-it's not and lik-like it actually makes my head hurt when I try, I've tried to make it the same I've tried to say well what's my trigger foods and yeah I do have trigger foods but I don't keep them in the house and I know if I have them

6:14 Chocolate was like massive, even now like I can go days without eating…… (4917:5056) - D 6: IN006

Chocolate was like massive, even now like I can go days without eating actual food and just live on chocolate [em] that's all I ever want.

6:17 Yeah but obviously I do have times where I eat too much and I know I e…… (5507:5662) - D 6: IN006

Yeah but obviously I do have times where I eat too much and I know I eat too much and it makes me will but I still do it [yeah] and I only eat when I'm home

6:19 I collapsed at work one day went to hospital and had my gallbladder ou…… (6175:6350) - D 6: IN006

I collapsed at work one day went to hospital and had my gallbladder out [laughs]. Ever since then I haven't been able to my relationship with food has just been horrific [em].

6:81 I don't know I suppose when I first got ill there was only so many thi…… (28265:28809) - D 6: IN006

I don't know I suppose when I first got ill there was only so many things, so many food groups that I could like well that I classed as like safe foods [em] and even then like id not eat diary, I'd cut out loads of food groups to the point that there was none left and then I introduced chocolate it didn't make me feel ill so I just controlled everything I ate [em] I don't know. Even now when I go shopping with my Mum she turns around

and says like ‘what can we have for meals?’ [Laughs] I don’t want anything [em] I just want binge food.

6:85 Mental health wise? [em] My OCD without a doubt. [yeah]. In turn that…… (33159:33343) - D 6: IN006

Mental health wise? [em] My OCD without a doubt. [yeah]. In turn that does affect my eating. So I really struggle with eating. I eat too much [laughs]. And then some time nots enough.

8:14 46 You know even though I didn’t have the ‘family’ dinner was still fa…… (2:223) - D 8: Interview 7

46 You know even though I didn’t have the ‘family’ dinner was still family time…em eh…it was nice we would sit down together even if it was just me and Mam you know and it was like that was time we spent together really.

- **Being dismissed**

11 Quotations:

1:80 Your you you don’t count. You know you don’t matter. What matters is t…… (24471:24667) - D 1: IN001

Your you you don’t count. You know you don’t matter. What matters is that you get through the day and then you keep the peace it doesn’t you know your feelings or whatever if doesn’t come into it.

2:22 Em basically when I did eh when I was young and slightly older questio…… (6379:6557) - D 2: IN002

Em basically when I did eh when I was young and slightly older question why because this was ongoing em I did question. I got told I was a spoiled little brat on one occasion eh.

2:34 Em I was getting increasingly upset and my brother arrived and basical…… (11284:11537) - D 2: IN002

Em I was getting increasingly upset and my brother arrived and basically spouted off the exact same thing that the doctors were saying was ‘it’s all in her head because of the emotional stress she is under’ yada yada em and I, I watched her go downhill.

2:40 Because like that was incredibly difficult watching her being forced t…… (12950:13281) - D 2: IN002

Because like that was incredibly difficult watching her being forced to sit in a hard chair

Yeah

And be in so much pain and then have nobody else actually acknowledging the fact that she is actually sick and of course you're fourteen so nobody listened to you [said through laughter] regardless of you're the one around her or not.

2:62 It's very upsetting because when I did try and discuss it; it was 'he'…… (21635:21790) - D 2: IN002

It's very upsetting because when I did try and discuss it; it was 'he's not here to discuss it so you can't discuss it this is what happened' kind of thing.

2:86 the whole nobody believed me about my Mum and the manner in which she…… (32646:32791) - D 2: IN002

the whole nobody believed me about my Mum and the manner in which she died and findings of what actually caused her death had a huge effect on me

2:104 I don't think she was fully aware no and she has passed comment that a…… (40114:40332) - D 2: IN002

I don't think she was fully aware no and she has passed comment that after that breakup that em I should not tell people because she feels that I either made it up or took it out of context.

So you not believed.

Yeah

3:6 I think of my sister as hurting me, em I just remember them talking ab…… (3442:3641) - D 3: IN003

I think of my sister as hurting me, em I just remember them talking about how they thought I would kind of like the things and just kind of making excuses that didn't make me feel any better [emhmm].

4:16 I also felt you know fairly ignored by my Dad cause like I got the pi…… (5520:5662) - D 4: IN004

I also felt you know fairly ignored by my Dad cause like I got the picture pretty soon that my Dad just kind of wanted to carry on like normal

8:16 You know I did tell my Aunt one day about the bullying, it was one tim…… (4915:5310) - D 8: Interview 7

You know I did tell my Aunt one day about the bullying, it was one time my Mam was kind out of it (depressive episode) but I got the like.. em.. well you think you have problems eh [said through giggle] it's just a silly schoolyard disagreement… em…sticks and stones and all that. But for me like it was a big deal you know.. I was miserable and then this reaction it eh just made me feel small.

8:17 Yeah I just didn't see my Dad and I didn't know why when I was small s…… (2247:2474) - D 8: Interview 7

Yeah I just didn't see my Dad and I didn't know why when I was small so I just thought it was my fault you know… I wasn't good enough em or whatever and thinking about it now it probably had a lot to do with my own problems - I

- **Eating to feel good**

8 Quotations:

3:23 Em I don't I don't recall how I was feeling when I was eating back the…… (10200:10454) - D 3: IN003

Em I don't I don't recall how I was feeling when I was eating back then I, I think I was numb [yeah] I mean I can recall how I feel when I eat now and it makes me feel better em so I imagine that's how I felt back then [yeah] but I don't really remember.

3:36 I don't even think I had that much insight into it, it was I really li…… (20480:20788) - D 3: IN003

I don't even think I had that much insight into it, it was I really like food [okay] it makes me feel good and it tastes good em I don't think I had that much insight to say I'm being teased and it makes me feel better about being teased I just remember thinking 'I just want food and it makes me feel good'.

3:59 Em yeah I mean looking back on it I eh you know I just, I just remembe…… (32438:32689) - D 3: IN003

Em yeah I mean looking back on it I eh you know I just, I just remember coming home from school and being very sad going directly to snacks not even snacks massive amounts of food and feeling good while I was eating [hmm] em and that's what I remember

4:49 Yes yeah and that really didn't become apparent to me until she starte…… (17660:17845) - D 4: IN004

Yes yeah and that really didn't become apparent to me until she started dieting she went on a liquid diet when I was in my teens and her not eating was miserable, she made us miserable.

6:15 And what do you feel like when you are eating chocolate? What does tha…… (5058:5420) - D 6: IN006

And what do you feel like when you are eating chocolate? What does that do for you? I just enjoy it like [em] I think cause I can't eat a very large amount of food anyway, I can only eat bits at a time [em] because I haven't got my gallbladder and I have loads of problems with my stomach that chocolate was so much easier cause it doesn't fill you up so much

6:72 So do you think any of this impacting your relationships with food, I…… (25014:25356) - D 6: IN006

So do you think any of this impacting your relationships with food, I mean your emotions if you weren't talking about them? Just eat [em] and it generally made me feel good and it still does. And all my family do it and my sisters picked up on it. We go to the shop and buy loads of food and just eat it all.

It makes you feel better?

Yeah.

8:5 It's hard, because that is still there em, eh... the memory that eatin…… (5466:5697) - D 8: Interview 7

It's hard, because that is still there em, eh... the memory that eating makes me feel good really quickly eh no matter how bad I feel… but now it just doesn't you know last so long and is more complicated. Back then it was simple.

8:6 So you know what I was thinking is that when I binge now it doesn't fe…… (4438:4890) - D 8: Interview 7

So you know what I was thinking is that when I binge now it doesn't feel good, it makes me feel out of control cause now I know the connection to my weight and health and all that em there is all the shame and you fat greedy... all that. But when I was young, I didn't really know so back then when I was having a hard time, you know feeling crap, eating made me forget all of that, it made me feel good… em… I really just liked it, like who doesn't?

- **Family emotional disconnection**

8 Quotations:

1:29 my sister dealt with it in her own way and my brother dealt with it in…… (7399:7577) - D 1: IN001

my sister dealt with it in her own way and my brother dealt with it in his own way but we could never sort of sit and talk openly about what was going on it wasn't that concept em

4:20 I feel like I knew he loved me [emhmm] but I felt dista- I just felt d…… (6342:6594) - D 4: IN004

I feel like I knew he loved me [emhmm] but I felt dista- I just felt distant and I certainly did not feel secure, secure enough to show him really like the type of affection that I would have wanted to show him [mm] I didn't feel comfortable doing that.

4:22 Oh she she really wants a close family she has always really wanted th…… (7448:7724) - D 4: IN004

Oh she she really wants a close family she has always really wanted that [mm] and she has that closeness with my Dad I think she always really wanted that for me as well [hmm] but also really acknowledging that she has no power over that [mm] so I think it's difficult for her

6:21 Eh as a kid, my family didn't hug, no one really if your upset you get…… (6862:7165) - D 6: IN006

Eh as a kid, my family didn't hug, no one really if your upset you get on with it, you go into another room and you get over it you just get over it [okay] that's how my family deals with things you get over it, if your ill you take paracetamol you get over it [em], laughs, it's just what they are like

6:24 Even now like if my sisters are upset then we just can't deal with it…… (7935:8067) - D 6: IN006

Even now like if my sisters are upset then we just can't deal with it like [said through laughter] we find it really awkward [em] so

6:33 Just awkward, I just can't do it. Can you say more about it being awk…… (10790:10939) - D 6: IN006

Just awkward, I just can't do it.

Can you say more about it being awkward? It's just something my family don't do, we don't open up. None of us do.

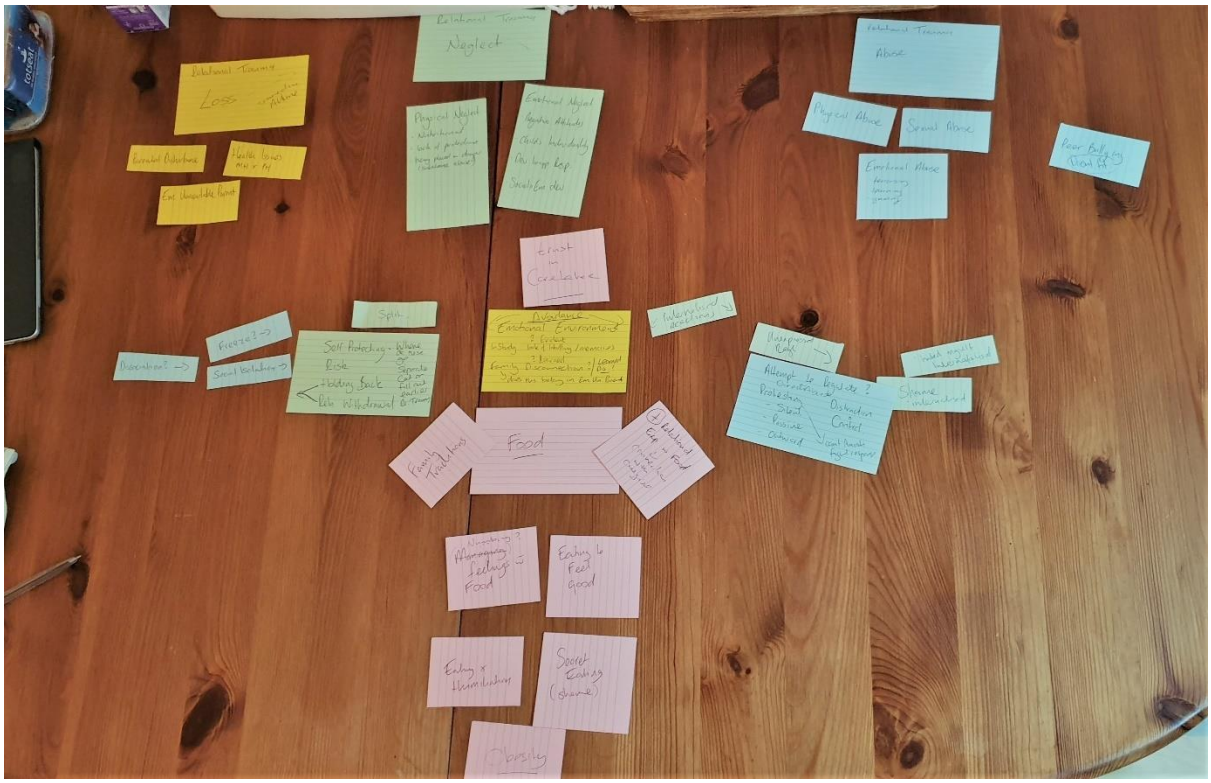
6:56 I just can't be bothered. My birthday for example he just put a card o…… (17747:17902) - D 6: IN006

I just can't be bothered. My birthday for example he just put a card on the porch and put £100 in [laughs]. That's it like we just don't have any emotions.

6:65 Cause I couldn't deal with her and I didn't want her, there. Cause I j…… (21959:22312) - D 6: IN006

Cause I couldn't deal with her and I didn't want her, there. Cause I just feel awkward around her if I'm ill or I don't want her there [okay] so my best friend came with me. Even today when I've got my endoscopy like I asked her if she can pick me up but asked all of my friends can they pick me up before [laughs] cause I did not want her there [em] so

Appendix VII – Example of diagram to organise categories



Appendix VIII - Excerpts from transcripts showing examples of peer checking

Peer Audit – Example 1

311 Where ever we were anyway we went shopping one day it wasn't I think it was a Saturday but my
312 Stepmum went off with my brother and I stayed with my Dad and, I remember oh I'll never forget it,
313 it was this like domed shopping centre [*mm*] I remember looking up at him and he was drinking out
314 of a silver flask like obviously a hip flask and still I wouldn't have known I mean I was a really really
315 innocent thirteen year old you know I was actually a really innocent eighteen year old [said through
316 laughter] but em still never thought anything of it and then we were driving back and this argument
317 started between him and my Stepmum, it transpires obviously he had been drinking and he was
318 driving us home and my Stepmum went mad and when we pulled up outside the house we got out
319 of the car myself and my brother and my Stepmum got out she went around to the driver's door
320 opened the door and got the keys out of the ignition and ran into the house and threw them into a-
321 into a kitchen cupboard and he was minding my Grandads dogs at the time cause he was obviously
322 away and my Dad kept saying, he must have been so drunk when I think about it, but he kept saying
323 'I'm bringing the dogs for a walk' and my Stepmum was like 'you're not driving' you know [*mm*]
324 and this humongous row erupted and he pulled the kitchen apart looking for these keys and
325 *Were you in there at the time?*
326 I was there but then my Stepmum said take your brother and go so I remember screaming at him
327 saying 'I'm going to ring the police. I'm going to ring the police'
328 *So you knew there was something wrong?*
329 Yeah and there was a phone box down at the end of the street back in the day [*mm*] and I think my
330 Stepmum had I remember my Stepmum saying 'go in next door' but I do remember him going [her
331 father] 'do it then, do it then, I don't care' and I did. I don't think I rang the police I remember being
332 in the phone box but I don't think I went through with it [*yeah*] and then we went back up and I
333 don't remember anything after that [*mm*]. But and I don't if this is the same day or not I haven't a
334 clue but I do remember I think my Stepmum must have gone off with my brother and left me with
335 him [*okay*] but I'm not sure about that I remember I was sitting downstairs and again as I say I don't
336 know if this was this time but it was one of the times and I know it's a big trigger for me, but I

10

remember him coming downstairs and he had a full suit on and it was evening time like there was no reason for it and he insisted on making me scrambled eggs and they were horrible he hadn't cooked them right and I remember trying to eat them and he was real maudli- he was a real maudlin drunk em

So what do you remember about that incident?

Well even though I'd eat scrambled eggs now it's not a repulsion I have about eggs I don't like snotty eggs as I call them [said through laughter]

Do you what the emotion behind it was?

Oh I remember being disgusted at him [*emhmm*] that I remember thinking, he was kneeling on the floor by me he was all being really lovey and I just remember thinking 'oh my god, you know, get away from me'.

I'm wondering as well about that really vivid memory of being so disgusted and him being overly maudlin [mm] *and I'm wondering then about the experience of abuse with the Grandad*

And I was, now this is an odd one and I don't, it's one of them ones where I don't know if it is real or not it's a memory I have [*yeah*] I don't know whether I made it up or whether, and it probably is real and then the emotions that I attached to it because of what happened to me [*mm*] but I remember being at my Dads house when I was probably about nine or ten so it would have been after the abuse and I remember going being, put in the bath or I was going for a bath before bed [*yeah*] and actually when I think back about it my Dad was probably drunk and I remember him coming into the bathroom and I remember feeling so vulnerable and I remember him washing me, sponge washing me [*mm*] between my legs, I don't, honestly don't think it was sexual [*mm*] I honestly don't [*mm*] but

But you were uncomfortable?

It made me feel like I was being abused [*yeah*] you know it did give me I don't think he was mentally doing and I think I found that hard to work that out [*yeah*] and even to say it when I've had

361 counselling or cause I'm like, I don't think but I know it made me feel the way I felt when [referring

362 to earlier sexual abuse she suffered]

363 *So it might have been that wasn't the intention but the boundary was crossed?*

364 And I was that was, I was standing in the bath and like the same time I was standing in the paddling

365 pool absolutely feeling that I-I really don't want this you know I don't like this and trying to cover

366 myself up and you know [*mm*] so yeah

367 *Yeah you are doing the same, the same expression when you are talking about it.*

368 Ugh yeah [*mm*] it was horrible and it's a really vivid memory but again I don't think he was abusing

369 me I think it was just cause he didn't touch me physically you know he washed me

370 *It sounds like as well you didn't trust your Dad.*

371 Well I obviously didn't but I mean huh I don't think I trusted any man to be honest at that stage

372 [*yeah*] I remember a friend of the families came I-I older now I was definitely thirteen fourteen and I

373 was babysitting one night th-this guy a friend of the families happened to call and Mum and my

374 Stepdad weren't there and he just gave me a hug but I remember 'oooohhhh, oh jesus don't'

375 *Don't come near*

376 And he wasn't doing anything he was just hugging me [*yeah*] and now there was nothing I remember

377 hating and not because I was scared of my Stepdad but because I hated being alone with him [*yeah*]

378 and in a sense of feeling really vulnerable not because I mean th-th-the bullying, that was as it was,

379 but I remember the terror of being alone with any man, the fear I had that fear of being abused or

380 anything like that all through, oh I remember all through my teens definitely [*yeah*] never wanting to

381 be on my own with a man, never.

Where ever we were anyway we went shopping one day it wasn't I think it was a Saturday but my Stepmum went off with my brother and I stayed with my Dad and, I remember oh I'll never forget it, it was this like domed shopping centre [*mm*] I remember looking up at him and he was drinking out of a silver flask like obviously a hip flask and still I wouldn't have known I mean I was a really really innocent thirteen year old you know I was actually a really innocent eighteen year old [said through laughter] but em still never thought anything of it and then we were driving back and this argument started between him and my Stepmum, it transpires obviously he had been drinking and he was driving us home and my Stepmum went mad and when we pulled up outside the house we got out of the car myself and my brother and my Stepmum got out she went around to the driver's door opened the door and got the keys out of the ignition and ran into the house and threw them into a- into a kitchen cupboard and he was minding my Grandads dogs at the time cause he was obviously away and my Dad kept saying, he must have been so drunk when I think about it, but he kept saying 'I'm bringing the dogs for a walk' and my Stepmum was like 'you're not driving' you know [*mm*] and this humongous row erupted and he pulled the kitchen apart looking for these keys and

Were you in there at the time?

I was there but then my Stepmum said take your brother and go so I remember screaming at him saying 'I'm going to ring the police. I'm going to ring the police'

So you knew there was something wrong?

Yeah and there was a phone box down at the end of the street back in the day [*mm*] and I think my Stepmum had I remember my Stepmum saying 'go in next door' but I do remember him going [her father] 'do it then, do it then, I don't care' and I did. I don't think I rang the police I remember being in the phone box but I don't think I went through with it [*yeah*] and then we went back up and I don't remember anything after that [*mm*]. But and I don't if this is the same day or not I haven't a clue but I do remember I think my Stepmum must have gone off with my brother and left me with him [*okay*] but I'm not sure about that I remember I was sitting downstairs and again as I say I don't know if this was this time but it was one of the times and I know it's a big trigger for me, but I

remember him coming downstairs and he had a full suit on and it was evening time like there was no reason for it and he insisted on making me scrambled eggs and they were horrible he hadn't cooked them right and I remember trying to eat them and he was real maudli- he was a real maudlin drunk em

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But you were uncomfortable?

It made me feel like I was being abused [*yeah*] you know it did give me I don't think he was mentally doing and I think I found that hard to work that out [*yeah*] and even to say it when I've had

counselling or cause I'm like, I don't think but I know it made me feel the way I felt when [referring to earlier sexual abuse she suffered]

So it might have been that wasn't the intention but the boundary was crossed?

And I was that was, I was standing in the bath and like the same time I was standing in the paddling pool absolutely feeling that I-I really don't want this you know I don't like this and trying to cover myself up and you know [*mm*] so yeah

Yeah you are doing the same, the same expression when you are talking about it.

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It sounds like as well you didn't trust your Dad.

Well I obviously didn't but I mean huh I don't think I trusted any man to be honest at that stage [*yeah*] I remember a friend of the families came I-I older now I was definitely thirteen fourteen and I was babysitting one night th-this guy a friend of the families happened to call and Mum and my Stepdad weren't there and he just gave me a hug but I remember 'oooohhhh, oh jesus don't'

Don't come near

And he wasn't doing anything he was just hugging me [*yeah*] and now there was nothing I remember hating and not because I was scared of my Stepdad but because I hated being alone with him [*yeah*] and in a sense of feeling really vulnerable not because I mean th-th-the bullying, that was as it was, but I remember the terror of being alone with any man, the fear I had that fear of being abused or anything like that all through, oh I remember all through my teens definitely [*yeah*] never wanting to be on my own with a man, never.

- feeling vulnerable, afraid
- associating : there is a sense that she is associating or interpreting certain situations / actions with what happened to her previously
- ambiguity / lack of clarity / lack of confidence as to whether these acts were sinister or she is casting a sinister view on them based on what has happened to her

Appendix IX – Ethics Approval Letter

METANOIA INSTITUTE

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Brigid Carley
DCPsych programme
Metanoia Institute

14th January 2015

Dear Brigid

RE: *Childhood experiences of women who are currently classified as 'obese'(ref: 6/14-15)*

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative for the Metanoia Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Research Subject Specialist
DCPsych Programme
Metanoia Research Ethics Committee

Registered in England at the above address No. 2918520

Registered Charity No. 1050175

Appendix X – recording stopped

tough time. But I was just more worried about is this was going to happen are we going to get
married em so I knew that was going on in the background but I didn't focus on it until a long time after so we got married and then he went back the next day and my Gran sent him she said 'oh I don't want you to get pregnant or anything like that until gets his proper papers and stuff' em

What was it like when he had to go back then after all of this focus and energy into this marriage,

Yeah yeah

Not just your marriage but it also sounds like for you personally?

Yeah yeah of course it was horrible horrible horrible time because fo- for you know I I was with I had my person and we were engaged for six months em although you know we didn't talk often we we did but and we were allowed to go out with as a family and stuff but he was my person my thing you know and em

It sounds like that relationship gave you something?

Yeah yeah it did he was my person and I just felt I was loved and all my concentration went on him

You felt you were loved

Yes and then he went and then off he goes and I had a year and a half without him and I was telling the children we didn't have all the social media in them days you know you had a £10 card and you'd get like a two and half minute phone call and then even then he never had a telephone in his home so he'd have to go across the road to the neighbours.

And what age were you at this point

I was seventeen

So how did you manage that, how did you deal with that year and a half?

Em it was it was a very hard time, actually I don't want this part to be recorded.

Recording stopped